Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) BENVENGA 3.46 PM January 25 1998 HNTHONY 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death NIA CENTER MERCY MEDICAL BALTIMORE if Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Deys 1 M 2 □ F Yrs. 7-1-1918 79 Maryland 573-16-9832 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits n/a Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of Whet Country? 145 S. Bouldin Street 21224 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes XX No if Yes, Give Year or Dates: 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore HVAC Engineer 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benvenga Antonina Caliri 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. informent's Neme/Relationship (Type, Print) Spouse 145 S. Bouldin St. Baltimore, Md., 21224 Grace Benvenga 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removel from State 1/28/98 Baltimore, Maryland Gardens of Faith 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Fecility Joseph N. Zannino Jr. Funeral Hm. 21. Signeture of Funerel Service Licensee 263 S. Conkling St., Baltimore, Maryland 21224 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death OBSTRUCTION MINUTES Due to (or es e consequence of): MINUTES CLOTT ENPOBRINCHIAL Due to (or es e consequence of): RECENT BROWENIECTASIS Due to (or as a consequence of): Pulmonary INFECTIONS 23b. Did tobacco use contributa to the cause of death? 1 10 10s 2 No 3 Probably 4 Unknown EMPHYSEMA 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy WITH COMPRESSION FRACTURES DISEASE 1 Yes 2 No 1 Yes 2 Tho Cohowary ARTERY 26. Plece of Deeth (Check only one)

Physician /Medical Examiner

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P.O. Box 68760,

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Attending Physician:

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Director

7 is marked other than "natural", or items 23s or 28s-f sho treumstic event, the Medical Examiner must be notified at

nit. Pages 1 end 2 should be filed within 72 hours efter armend of Health and Menelle Hygiene. Orden: If flam 27 is marked other than "natural; or flee injury or other traumatic event, the Medical Examina

Baltimore, Maryland 21215-0020

with the Meryland

death

5. Social Security Number

10e. Street end Number

Salvator

20e. Method of Disposition

10a State

Director

Funeral

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Completed

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Lest

Immediate Cause (Final disease or condition resulting in deeth)

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

ATHEROSCLEROTIC

25. Was case referred to medical exeminer? 1 Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work?

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

2 ☐ Accident 3 ☐ Suicide 4 Homicide

27. Manner of Death

1 Netural

6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as steted.

2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Dav. Year)

29b. Signature and title of certifier

5 Pending investigation

1 ☐ Yes 2 ☐ No

eeth (Item 23e) (Type, Print) UNIVERSITY OF MARYLAND, 10 S PINE ST, KOOM 800, BALTMORE, 2/201

DHMH 16 Rev 6/95

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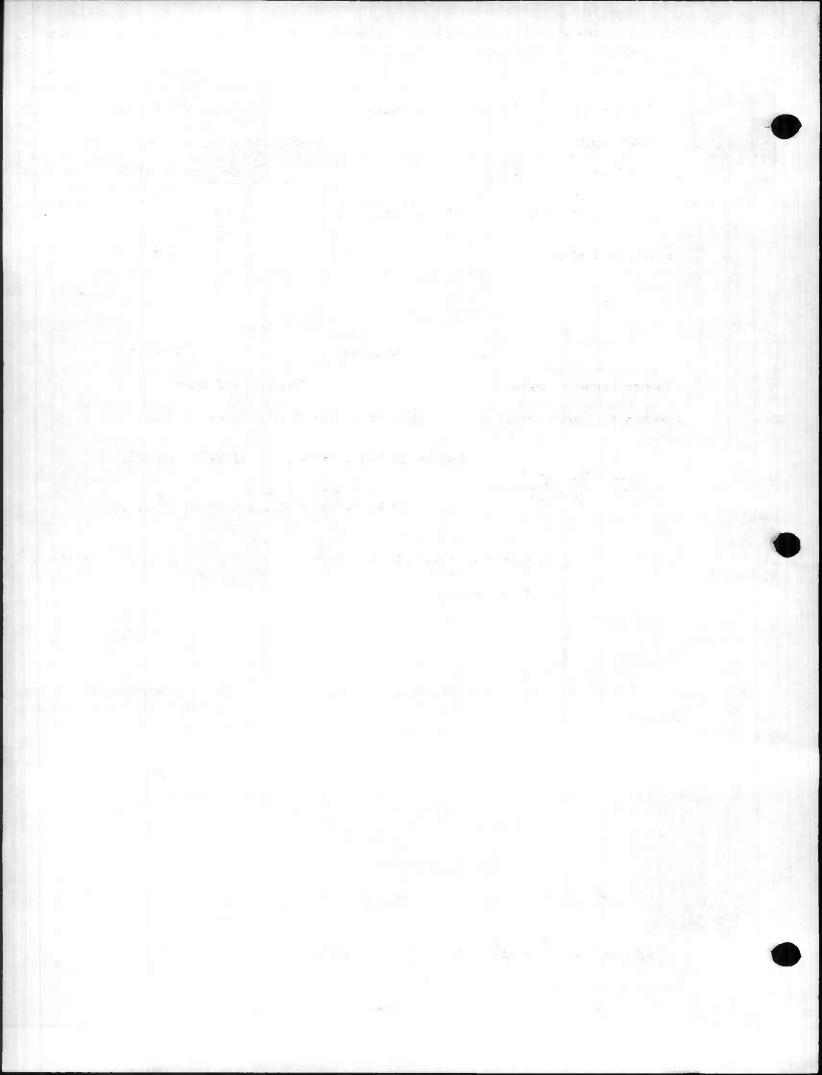
Registrar

2. Registrer's Signeture

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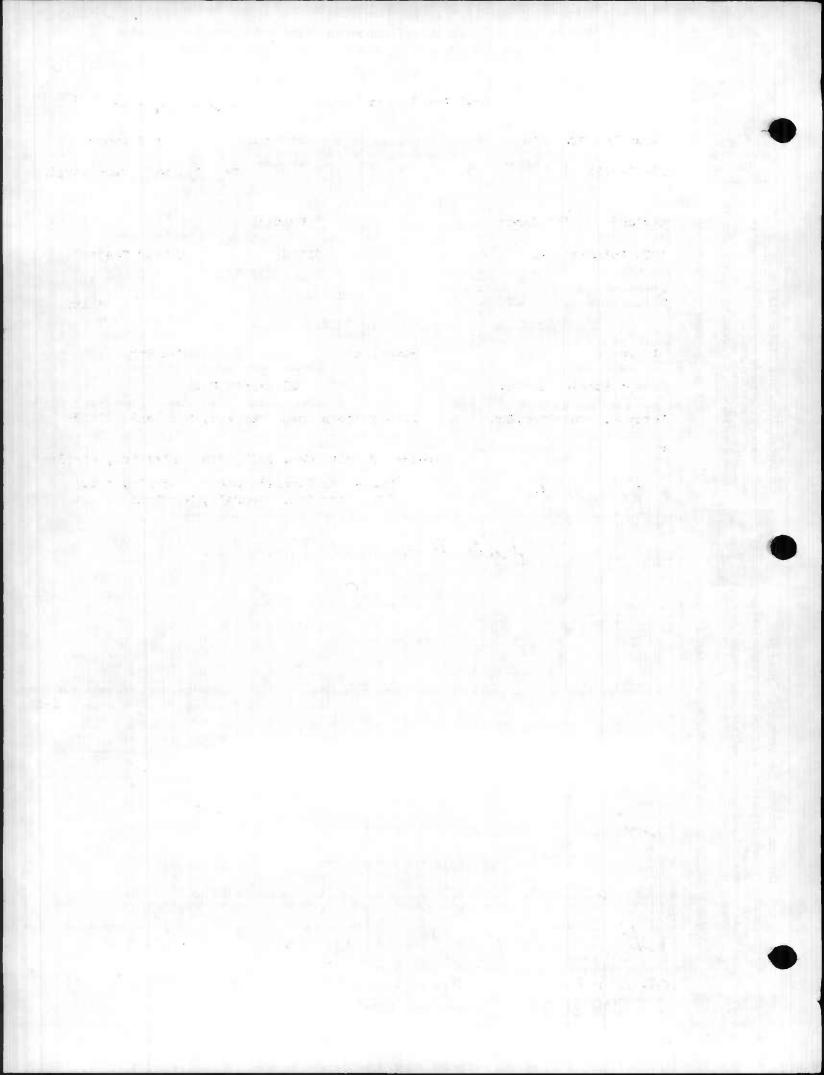
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time f th **Physician** Month Elizabeth Elaine Begenau January 27,1998 3:00 a.m. /Medical 4a. Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BROADMEAD Baltimore 5. Sociel Sacurity Number 8. Data of Birth (Month, Dey, Year) January 18 9. Birthplece (Stata or Foraign 1915 New York 7. Aga (fn yrs. last birthday) **Funerai** 1□ M 9 F 054-22-1755 83 Director Yrs. Usual Rasidenca of Decedant Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiena. 10a State 10b. Count 10c. City, Town or Location 10d. Insida City Limits "naturel", or items 23a or 28a-f show MD **Baltimore** Cockeysville 1 Yes 2 No Director 10e. Straat and Numbar 10f. Zip Coda 10g. Citizan of What Country? 13801 York Road 21030 USA Completed by Funeral 11. Marital Status 12. Was Dacadant Ever in U,S. Armad Forcas? 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indien, Bleck, Whita, atc. 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Datas: 1 ☐ Nevar Merried 2 ☐ Married Baltimore, Maryland 21215-0020 White 1 Yes 2 XNo 3 Widowad 4 Divorcad the Medical 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry nd Mental Hygiena. marked other than Elementery/Secondary (0-12) College (1-4or 5+)
5+ Librarian Education traumatic event, 17. Fethar's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maiden Sumema) Be Thomas Francis Smith Lucinda Collamer 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Code)
1031 Pine Hill Rd., McLean, VA 22101 19a. Informent's Name/Ralationship (Type, Print) Health 8 Bronwen B. Lewis/daughter or other t 20b. Pleca of Disposition (Nama of cametery, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata Department if important: if any injury or 1/27/98 Baltimore Wash. Crematory Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Lemmon Funeral Home 23a. Part1. Entar tha diseesa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or respiratory errast, shock, or heert feilure. List only one cause on each line. Michael Flagle Approximata Interval Betw Onsat and Daath **Physician** /Medical Immadiate Causa (Final 2444 a CEREBOUASCULAR Accident disaase or condition rasulting in death) **Examiner** Dua to (or as a consequence of): 114PGT603100 Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Disaesa or injury that Initieted evants rasulting in daath) Last Dua to (or as e consaquance of): The law requires that the death certificate be exe Box 68760, Physician/Medical 8 Due to (or as a consequence of) Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobecco use contribute to the causa of deeth? ă 1 Yes 2 No 3 Probably 4 Unknown DEMONTIN þ 2 page 2 should Completed 24a. Wes en autopsy performed? 24b. Were eutopsy findings availabla prior to complation of causa of daeth? this certificate 1 Yas 2 No 1 ☐ Yes 2 ☐ No Be 25. Was casa raferrad to medical 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Othar: 4 M Nursing Homa 5 ☐ Rasidenca 6 ☐ Othar (Specify) 1 Yas 2 No 2 27. Mennar of Death Certification: 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Affier 5 Pending investigation 1 Naturel 1 Yas 2 No 2 Accidant etor 3 Suicide 6 Could not be 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 Homicide 1 Cartifying Physician: To the bast of my knowledga, daath occurrad at tha tima, data and pieca, end dua to tha causa(s) and menner es steted. 29a. Cartifiar (Check only one) 2 Medical Examtnar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the causa(s) and manner stated. å 29b. Signatura and titla of cartifier 29c. Licansa number 29d. Data signed (Month, Day, Year) olert 1-27-98 30. Name end eddrass of person who completed use of deeth (Item 23a) (Type, Print) RH WIEDEFELD 1380 Cockessine Rel 31. Date filed (Month, Day, Year) 32 Registrar's Signatura State wie Davidson Randala 28 1998 Registrar



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State Registrar



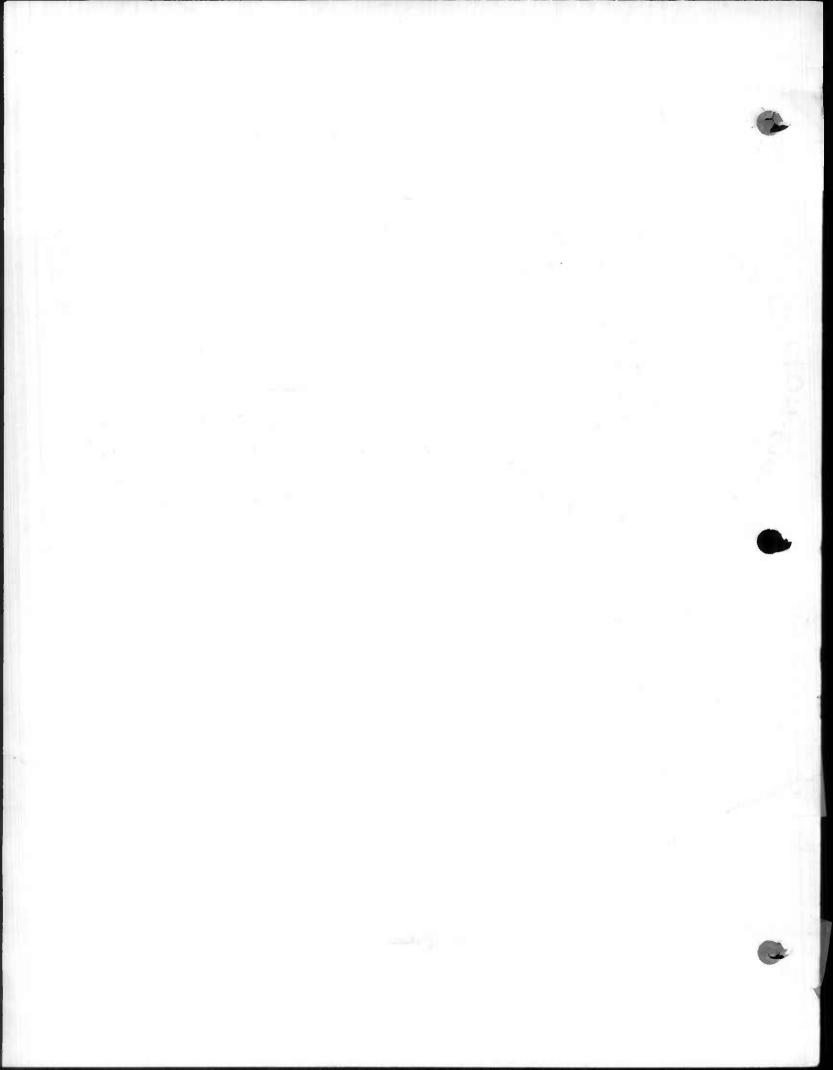
State of Maryland / Department of Health and Mental Hygiene 8 02004

					Ce	rtificat	e of	Death			Reg. No.	UL	004
	Physician	Decedent's Name (First, Midd	le, Last)	orothy	Marie	Ва	arro	on		2. Dete of De		Year 1998	3. Time of Death 10:37 AM
)-	/Medical Examiner	4a Facility Neme (If not institution 500 South Bo								e City	4c. County	of Death	N/A
	Funeral Director	5. Social Security Number 246-44-8120	6. Sex 1 □ M 2XXF	7. Age (In yrs. I	est birthday) Yrs.	If Under Months	1 Year Days		24 Hrs. Min.	8. Date of Bir (Month, Da Sept.	th Y. Yeer) 30,1931	Coun	lece (Stete or Foreign try) th Carolina
	vith the Maryland or 28a-f show be notified at	Usuel Residence of Decedent 10e. State 10b. County Maryland	N/A	10c. City	y, Town or Lo	ocation		Bal	timo	re City			0d. Inside City Limits 1 🛱 Yes 2 🗆 No
	23a or 2		ouldin Str	eet		10f. Zip	Code	21	224		10g. Citizen of Unite		,
020	72 hours after death with the Maryland natural; or items 23a or 28a-f show deal Examiner must be notified at shed by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	ried Armed For	2 ₹ No e		Wes Deced If Yes, spec				ecify Yes or No Rican, etc.)	14. Rac Bie	ck, White,	
5-0		15. Deceder (Specify only higher	nt's Education est grede completed)		(Give	dent's Usue	rk done	dunna mos	at of work	ing	16b. Kind of B	usiness/Inc	Justry
21215-0020	yiene.	Elementary/Secondery (0-12) 6 Years	College (1	-4or 5+)		<i>po nor</i> u		ed)			Own	Home	
Maryland	De fill	17. Father's Neme (First, Middle,	Last)					18. Mothe		e <i>(First, Middl</i> e ha Ormo	, <i>Meiden Sum</i> er nd	me)	
ary	2 should be and Mente Is marked sumatic or	19e. Informent's Name/Reletion: Wilbur G. Cox		Son	19b. Maili	ing Address	(Stree	t end Numb	er or Rur	ral Route Numb	er, City or Town	, Stete, Zip	Code)
x 68760, Baltimore,	certificate be executed . xii . ya . Department . ya	Ceuse (Diseese or injury thet initiated events resulting in death) Lest	nimplications thet can be a superior one cause on each	aused the deeth ach line. Sudd Due to (or	n. Do not en	2. Name and Duda—7922 atter the model quence of the quence of the property of	Ruc. Wisde of dy	ess of Fecili k Fund e Ave , ing, such es	eral Di cardiac	undalk, or respiratory a	Middle f Dunda: Marylan mest, dys	lk, I	
of Vital Records, P.O. Box	hystolan: The law requires that the death his certificate has been signed by the atter all director, page 2 should be detached for TO Be Completed by Physicial	25. Was case referred to medical examiner?	stive	e Mile o	laide Le	Mo to pe	ty la	Le Lu Zé. Pleciher: 40 N	The	24a. Wes perfe	Yes 2 No one)	3 Prof	bably 4 Unknown ere eutopsy findings elieble prior to mpletion of cause deeth? Yes 2 No
Division	Lai or Attanding is after death. In Director: After ed in by the fune Certification	27. Menner of Death	not be nined 28e. Placa buildir	of Injury - At hong, etc. (Specify		M reet, fector	y, office	Yes 2		28f. Location (City or To	wn, State)	ber or Rure	of Route Number,
	in 24 hours in 24 hours he Funer pletely fill edical	29a. Certifier (Check only one) Certifying (Check only one)	ng Phyeiclan: To the Examiner: On the ba end mann	sis of exeminet	wledge, deat tion end/or in	th occurred execution	et the t	ime, date er opinion, dee	nd place, oth occur	end due to the red et the time,	ceuse(s) end m date end place,	enner as s end due to	teted. the cause(s)
	within 2 To the comple	29b. Signeture and title of certifie		MI)	290	c. Licen	se number	26)	29d. Date sign	od (Month)	Dey, Year)
	12	30. Neme end eddress of person Christine Harte		e of deeth (Item 9 Easte			.1+4	maxa	MT	21224			
	State	31. Dete filed (Month, Day, Year,	32. Fy	istrer's Signe	ture		a I C I	more,	רוויז	21224			
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THE STATE OF THE S and street and in the same of the same and place of the contract of t The Verset Report Institution . and the second second second second The shall be a state of the sta

BALTIMORE, MARYLAND 21215-0020	A hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	he medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fu hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTE	AR	STATE OF N	IARYLAN	D / DEPAR	TMENT O	F HE	ALTH AND I	MENT	AL HYGIEN REG. NO.	E		
	1. DECEDENT'S	NAME (First, Middle, La	M.	Bo	15+L	uick			2. DAT	E OF DEATN	"- 199		3'20 P. M
		URITY NUMBER	5. SEX		rs. lest birthday)	IF UNDER 1 YE		IF UNDER 24 HRS.	7. DAT	E OF BIRTH	8.	BIRTNPL	ACE (State or Foreign
	}	1-9603	1 🗆 M 2 🔀 F	9	7 YAS.				мау	20 1	900		ginia
<u>«</u>	N .	AME (If not institution, gi	ve street and number)			Balt		LOCATION OF DI	EATN		9c. COUNTY	v of deal	rn .
18	RESIDENC	OF DECEDENT											
DIRECTOR	10e. STATE	10b. COU				Y, TOWH OR L	OCATIO	ON .				1.5	d. INSIDE CITY LIMITS?
	MD.	Hari	ora		Be	l Air	10f. 2	ZIP CODE			10g. CITIZE		T COUNTRY?
FUNERAL	108	West Heat	ther Rd.				2	1014				USA	A
I S	11. MARITAL ST		12. WAS DECEDENT FORCES? 1	EVER IN U.	S. ARMED	13. WAS	DECEN	NDENT OF NISPAI	NIC ORIG	ilN? (Specify Yes	or No- 14	Black, V	- American Indian, Vhite, etc.
B		4 Divorced	IF YES, GIVE W					NO Specif		•		Specify:	White
G		15. DECEDENT'S I (Specify only highest go	EDUCATION rade completed)	18	a. DECEDENT'S	USUAL OCCU			10	Sb. KIND OF BUS	SINESS/INDUS	STRY	MILLO
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E 111	Hild	ridae		Mo	Cready			-Eda-		,	ETTA	A V	Vest
TO B		T'S NAME (Type/Print)			7		treet enc	1 Number or Rural	Route Nu	mber, City or Tow	n, State, Zip Co		
			ler/Nephew					er Rd.					
ISAU	14 Burial 2	F DISPOSITION Cremation 3 F 8 Cher (Specify)	lemoval from State	cemeter	ACE AND DATE ry, cremetory or o	of Disposition there piece in the company of the co	ON (Nem		29-9		cation — ch odlawi		
	-	OF FUNERAL SERVICE	LICENSIA	- T WOC	XIIAWII	22. NAI	ME AND	ADDRESS OF FA	CILITY				•
examiner must be notified TO BE	\	15	1	guryin				Towson					
шедіся	23. PART I. I	nter the diseases,	or complications that	coused th	ne death. Do	not enter the	mod	York Rd	th as ca	or reap	ratory arrea	204. it,	Approximate
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C event,			- HYPHYD	729 ICI	ILC CO	DDION	ACC	11140	DIS	IM. CE			V124-01
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CERTIFICATION	that initiated resulting in		DOE 10	OH AS A CC	MSEQUENCE O	-);							
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PHYSICIAN: MEDICAL		HRONIC		death but	not resulting	in the unde	riying	cause given in	Part I.	24a. WAS AN PERFOR	MEDS	A	ERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE
MS 2		11-01010	7(100 = 1777							1 TYES 2	NO	D	F DEATH?
N. N	DID TOB	ACCO USE CO	NTRIBUTE TO CA	USE OF	DEATH Y	ES 🗆 NO	M	UNCERTAI	N \square				
item 23 shows any SICIAN: MEDIC	25. WAS CASE EXAMINER	REFERRED TO MEDICA	HOSPITAL:	26.	PLACE OF DEA	TH (Check only	one)						
YS.	1 TYES		1 Inpatient 2 I		ont 3 DOA	4/S Nursing	Home c. INJUI	5 Residence			. Illey occur	DEG	
	1 Natura	5 Pending	(Month, D.			JURY	WOR	K? NO	280. 0	ESCRIBE NOW I	NJOHY OCCU	HEO	
D BY	2 Accide 3 Sulcide	8 Could not	28e. PLACE O	F INJURY atc. (Specify)	At home, ferm,	street, tectory.	office		281. LC	CATION (Street of ty or Town, State)	and Number or	Rural Rou	te Number,
ETE	4 Homic	,	d										
MPORTANT: IT NOM 28 IS D BE COMPLETED	(Check only one)	CERTIFYING PI	NYSICIAN: To the best of MINER: On the bests of st										nd menner ee stated.
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TO BE	YEAR	m/ 2.	Obym	D.				D-19	42	7	▶ 1/	27/	98
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	31. DATE PILED	1°28 1998	3 AFOISTE	R'Ş SIGNATU	Pandell.							•	



			-	tificate				lental Hy	9.011	0	UZU	UO
Decedant's Name (First, Middla	(ast)		081	uncate	, OI L	Jealii		2. Date of De	Reg. N	0.	2.7	ima of Death
VINCETTA	i, Lasi)		R	ATTH	700	TA		Month	D	ay Ya	aar	
4e. Facility Nama (If not institution	aive etreet and numb	or)	2				n or Lo	JANUA ocation of Deat	. 1	27 /		:10 pm
		91)							440		Jean	
Good Samarita 5. Social Sacurity Number		Aga (In vrs. las	t birthday)	If Undar 1	Yaar	Balt If Undar 24			rth	N/A	Birthpleca (Stata or Foraign
213-03-3751	1□M 2XF	82	Yrs.	Months	Days	Hours	Min.	8. Data of Bi (Month, Di April	1 1		Country) Maryla	
Usuel Rasidance of Decedent		-02						Uhitt		1212	naryra	
10a. Stata 10b. County		10c. City,	Town or Loc	cation								sida City Limits
Maryland N/A		Balt	imore								1,0	Yes 2□No
10e. Street and Number				10f. Zip 0	Coda				10g. C	tizan of Whe	t Country?	
3203 Glenmore	Avenue			212	214				Uı	nited	States	
11. Marital Status	12. Was Decede Armed Force	nt Evar in U,S.	13. V	Vas Decede Yes, specif	nt of Hi	ispanic Origi n, Mexican,	n? (Spe Puarto	ecify Yes or No Rican, atc.)	D-		American Ind Whita, atc.	ian,
1 Never Marriad 2 Marri	ed 1 Tas 2	No No		☐ Yas 2		Specify:				Specify:		
3X Widowed 4 □ Divorced	Yaar or Data			diamen								
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Elementary/Secondery (0-12)	Collega (1-4	or 5+)				,				0 11		
17. Father's Name (First, Middla, L	ast)		HOIII	emaker		18. Mothar	s Nama	a (First, Middle	. Maida	Own H	ome	
Signorino Pres	tianni											
19a. Informant's Name/Ralationsh			19b. Mailin	a Address /	Street s			Bonsig			te Zin Code)
Anthony Battag						ark Ro					21128	
20a. Mathod of Disposition	114 / 5011	20b. Plac	e of Dispos	sition (Name	a of		Jau	Date			or Town, St	
1 □XBurial 2 □ Cramation 4 □ Donation 5 □ Othar (Sp		ite		atory or oth		*		/20/00	Del	ممد	- Main	
21. Signatura of Funaral Sarvice L	•	S. Harm	an 22	Nama and	Addres	s of Facility		/30/98			e, Mar	yrand
1 Tuintle	2 House	Ji Ikuili	Le	eonard	j J.	Ruck	Fur	neral H				
23a, Pert1. Entar tha disaase, or o	complications that cause	sad the death	Do not anta	305 Ha	arfo	rd Ro	ad	Baltim	ore.	MD 2		oximata
23a. Pert1. Entar tha disaase, or o shock, or haart feilura. List o	only ona causa on each	h lina.	DO HOL AIRE	ii tiio iiioge	OI Gylli	g, such as ce	arolac	л тазрнатогу е	most,		interv	rel Batween t and Death
Immadiata Causa (Final	7000	4T D	ECAT	010	ne	Y 05	-	1500	c41	IDEOR	1=	. ,
disaase or condition resulting in daath)	a. Aou:	u RI	=>1-1	JCPE /	0/0	()1	-5//	CCSS	>//	DRUT	6	days
	ь. Аси	Dua to (or a	s e consaqu	uanca of):	-1-		_				17	1-
On a self-the transport	b. HCU			9	7-1	CLIK					1	ray's
Sequantially list conditions, if eny, leeding to immadiata cause. Entar Underlying	E	Due to (or a									7~	·
Cause (Diseasa or injury that initiated evants	c	Due to for e	S a conseni	ience off.	2						+00	3.
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	- UFSC	1127011	, 20	-101	, -/		- ent en		77.0			75
	d	-										
Part II. Other significant condition								1				ause of death?

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trensit

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygione. Important: If item 27 is merikad other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

by Funeral Director

Completed

Be 10

Sequantially list conditions, if eny, leeding to immadiata cause. Enter Underlying

Cause (Diseasa or injury that initiated evants	C	JEPSI			terays.
rasulting in deeth) Lest		or es a consequence of	•	CAR COAC-UL	OPATHY 3 days
Part II. Other significant conditions co	ntributing to death but not ra	sulting in the undarlying	causa givan in Part I.		ontribute to the cause of death?
				1 ☐ Yes 2 ☑ No	3 ☐ Probably 4 ☐ Unknow
				24e. Wes en autopsy performed?	24b. Wera autopsy findings evailable prior to completion of cause of death?
				1□ Yas 2 🗹 No	1 ☐ Yas 2 ☑ No
25. Was casa rafarred to medical axaminer? 1 □ Yas 2 ☑ No	Hospital: 1 ☑ Inpatiant 2 □	☐ ER/Outpetient 3☐ [Othor	eath (Check only ona) Homa 5 □ Rasidance 6 □ Ot	thar (Specify)
27. Menner of Daath 1 ☑ Netural 5 ☐ Pending 2 ☐ Accidant investigation	28e. Deta of Injury (Month, Dey Year)	28b. Tima of Injury M	28c. Injury et Work? 1 Yas 2 No	28d. Dascribe how injury occu	
3 Suicida 6 Could not ba 4 Homicide determined	28e. Plece of Injury - At I building, atc. (Speci	nome, farm, streat, factorify)	ory, office	28f. Location (Straet end Num. City or Town, Stete)	nber or Rural Route Number,
29a. Cartifiar (Check only one) 1 Certifying Phy	sician: To the best of my kniner: On the basis of examinant and manner stated.	owledga, daath occurre ation and/or Investigation	d et tha tima, data and pled on, in my opinion, death occ	ce, end due to the ceuse(s) and mourred at tha tima, date and place	nannar es steted. e, end dua to tha causa(s)
29b. Signature and little-of certifier		2	9c. License number	29d. Deta sign	ed (Month, Day, Year)

State Registrar

Dr. Gilbert Zoghbi
31. Data filed (Month, Day, Year)

Good Samaritan Hospital 5601 Loch Raven Balto. 21239

P 11389

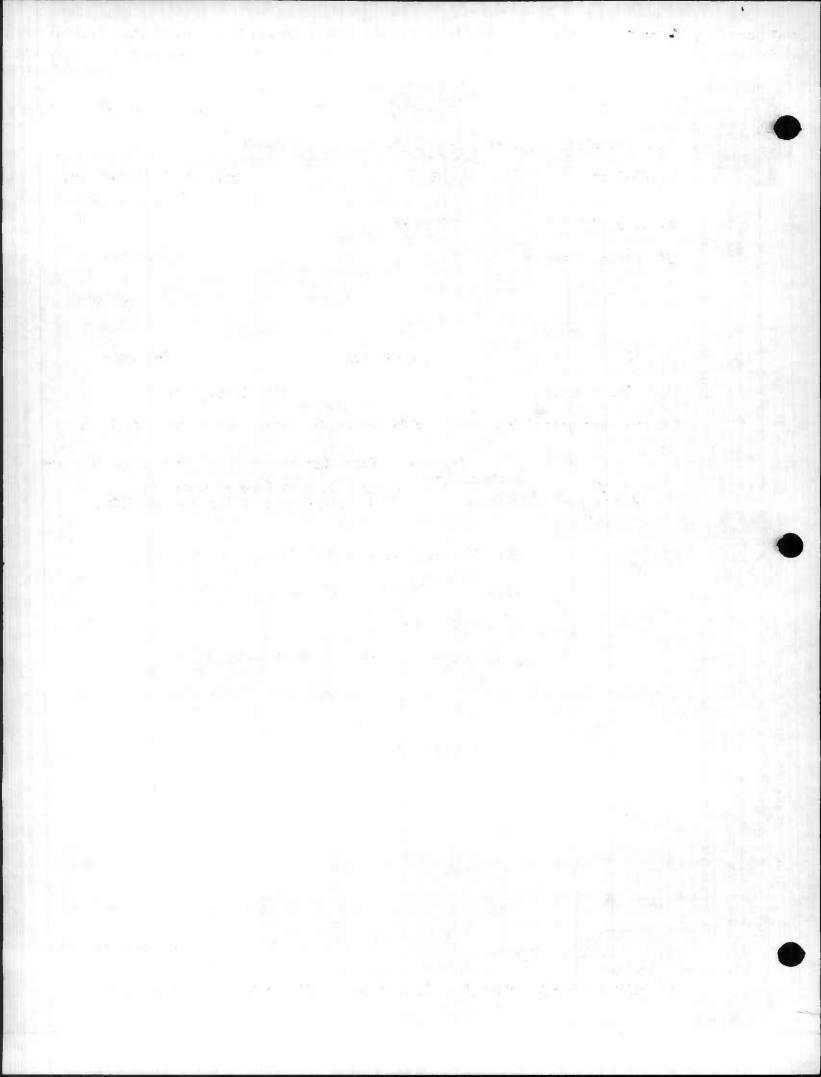
JANUARY 27, 1998

JAN 28 1998

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print)

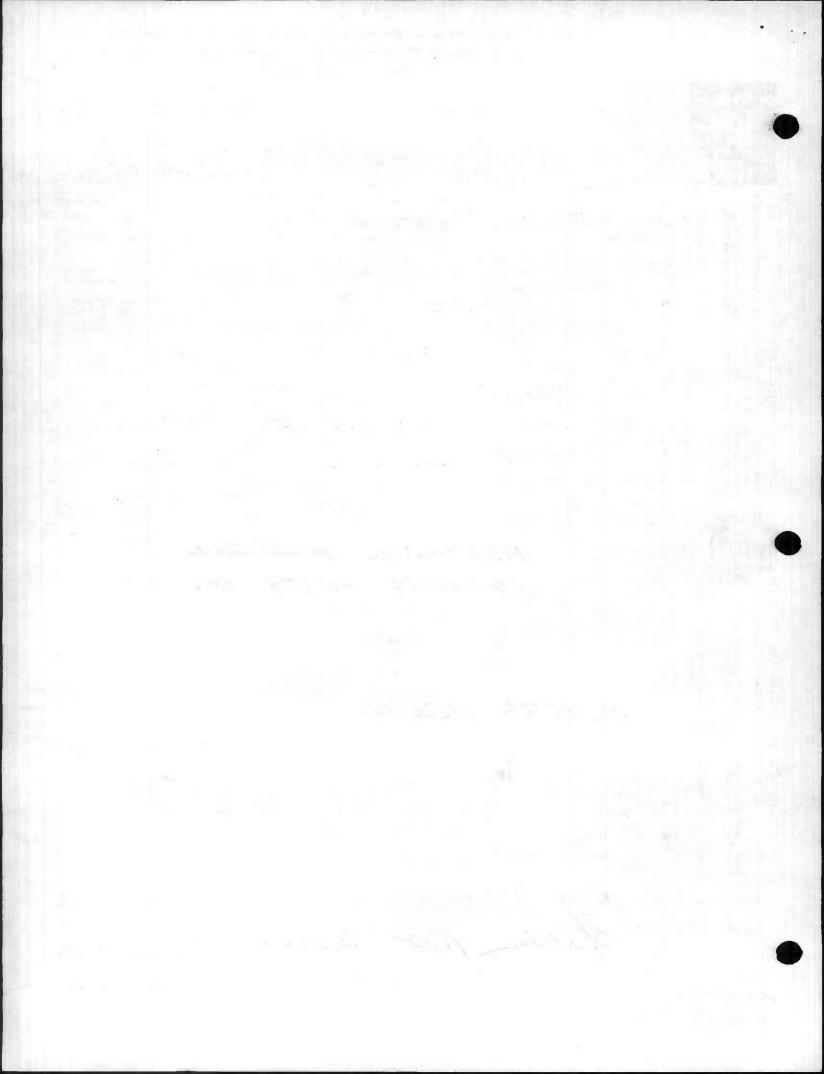
32 Registrer's Signatura

Jundon-Randolle



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					00/11	ficate of	Double		Reg. No.		
Physic	ian	Decedent's Neme (First, Middle, Land)	ast)	^	5.			2. Dete of Dec	eth Dey	Yeer 3.	Time of Deeth
/Medi		THADOSUS	HARROL	BEC	ik			JANUA		198	ILAM.
Exami		4a. Fecility Neme (If not institution, gir	ve street end number)				4b. City, Town, or	Location of Death	4c. County	of Deeth	
		20502 010 406	2K ROAC			1	ZTIKW	HALL	BALT	moRE	
Funeral				ge (In yrs. lest		If Under 1 Year Months Deys	if Under 24 Hrs Hours Min.	8. Dete of Birt (Month, De	h		(Stete or Foreign
Director	п	414 03 2956	M 2□F	18	Yrs.	WOTHITS DOYS	TIOUIS WIII.	MARHS	1919	MARYL	And
2		Usuel Residenca of Decedent	-						1		
arylar show	_	10a. Stete 10b. County		10c. City, To	own or Local	tion					nside City Limits
W M	cto	MARYLAND BALLIN	roRs_	Mi	HITZ	HALL				1	☐ Yes 281No
5 2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Sire	10e. Street end Number	0			10f. Zip Code			10g. Citizen of V	Whet Country?	
death with the Meryland rms 23a or 28a-f show	ai	20502 OLD Y	ORK ROA	Ω		211	H		12-51	.A.	
dea dea	Funeral Director	11. Marital Status	12. Wes Decedent Armed Forces?	Ever in U,S.	13. We		lispenic Orlgin? (S en, Mexican, Puer	pecify Yes or No	14. Rac	e - American In	dian,
72 hours after natural, or ite		1 ☐ Never Married 2 ☐ Married	Yes 2 If Yes, Give			Yes 20 No	Specify:	to ricall, etc.)	1	ck, White, etc.	
Par.	by	≫ Widowed 4 □ Divorced	Yeer or Detes:\	IEW.W		THES ZEELING	<i>Зреспу.</i>		Specify	THE W	5
72 h 72 h	Completed	15. Decedent's E (Specify only highest gr	ducation	10	6e. Deceder	nt's Usuel Occup	etion	rkina	16b. Kind of Bu	usiness/Industry	1
d within 72 hours af giene. or than "natural", or the Medical Evam	npie	Elementery/Secondery (0-12)	College (1-4or :	5+)	life. DO	NOT use retire	during most of wo	, nailà	0 0		
filed within Hygiene. rther then	6	iayrs.		. (JAC	Hinis			A. P.	G.	
be file d offh	Be (17. Fether's Name (First, Middle, Last	t)				18. Mother's Ne	me (First, Middle,	Meiden Suman	10)	
d 2 should be file th and Mental Hy 7 is marked othe traumetic event	To	WALTER B.	EKSINCK!				CAT	ASRINE			
2 should be and Mental is marked o		19e. Informent's Name/Relationship	(Type, Print)	1	9b. Mailing	Address (Street	end Number or R	ural Route Numbe	er, City or Town,	Stete, Zip Code	19116
C = 0 F		MARY PATRICIA	BICK	a	KD.502	LOIDY	LOOK RO	IAN PA	RKTOO	MAR	MANN
emit. Pages 1 e popertment of Hea moortant: If Item: In Injury or othe		20a. Method of Disposition	2	20b. Piece	of Dispositi	on (Neme of		Dete	20c. Location -	City or Town, S	State
Pages nent of nt: If lit		Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special		_		tory or other ple	-	180.30		0	0.00
permit. Pages Depertment of mportant: If it my injury or one.		21. Signature of Funeral Service Lies		GAR	RISON		es of Facility	1998	GARRIC	201/11	HRYLAR
Depentit. Depentit Importa		11000			EV	HOUSE EMP		Himes			31003
100	ш	Mark AKI	The dies			32 YOR) Timo	rium!	HARYL	AM
		23a. Pert1. Enter the disease, or com shock, or heert feilure. List only	one ceute on each li	ne.	o not enter	the mode of ayli	ng, such es cardia	c or respiretory er	rest,	Inter	roximate rvel Between
Physician /Medical	П	Immediate Course (Fine)	11.10	-1-0	1.0			0000	. /	Olis	et end Deeth
Examiner		Immediate Cause (Final disease or condition resulting in deeth)	MYO	11/6	1 1/1						
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sit ed	Ψ Ψ		000	-			NHIK	CITON	· ,	1	
and trar	듣		COR	-			N FFIK TERY	DIS			
	xamin	Sequentially list conditions,	b. COR	-	a conseque	nca of):	RERY	DIS	. ,		
cian cian	al Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury	b. COR	Due to (or es	a conseque	nca of):	NIAK TERY	DIS			
sate be ex physician the burial		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest	b	Due to (or es	a conseque e conseque	nca of):	NERY	DIS			
artificate be executed ing physician and e as the burial-transit	edicai	thet initieted events	b	Due to (or es	a conseque e conseque	nca of):	RERY	DIS			
Ith certificate be extending physician or use as the burial	edicai	thet initieted events	b	Due to (or es	a conseque e conseque	nca of):	NERY	DIS			
e death certificate be ex he attending physician s ted for use as the burial	edicai	thet initieted events	c	Due to (or es	e conseque	nca of): nca of): nce of):	PERY	23b. Did (obacco use co	ntribute to the	cause of death
at the death certificate be exact by the death certificate be exact by the attending physician selected for use as the burial	edicai	resulting in death) Lest	cd	Due to (or es Due to (or es Due to (or as	e conseque e conseque g in the unde	nca of): nca of): nce of):	TERY ven in Pert I.	23b. Did 1			
hat the death certified by the attending	Physician/Medical	resulting in death) Lest	cd	Due to (or es	e conseque e conseque g in the unde	nca of): nca of): nce of):	PARY ven in Pert I.				
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State of Maryland / Department of Health and Mental Hygiene R Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Buriak **Physician** 0 William ation of Death | 4c. County of Death /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore JOHNS HOPKINS HOSPITAL N/A If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (State or Foraign Country) **Funeral** 088-09-1775 1 M 2□ F 80 Yrs Director May 7, 1917 Pennsylvania Usual Rasidance of Decedant the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23a or 28s-f show other traumatic event, the Madical Examiner must be notified at 1 Yas 2 No Director Cambria Mineral Point 10a. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 869 Pike Rd. 15942 USA permit. Pages 1 and 2 should be filed within 72 hours after deeth v. Department of Health and Mental Hygiene. Important: If ifem 27 is marked other than "natural", or items 23s any Injury or other traumatic avant Funeral 12. Was Decedant Evar In U,S. Agned Forces? 1 ∑ Yes 2 □ No If Yas, Giva Yaar or Datas: 1942-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) Race - Amaricen Indian, Black, White, etc. 11. Maritel Status 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Steel Worker Steel Manufacturing 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Surname) Be Phillip Buriak 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stete, Zip Code) William Buriak (Son) 39 Riverbend Rd. Clinton, NJ 08809 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 4 ☐ Donation 5 ☐ Othar (Specify) St. Johns Orthodox Cem. 1/29/98 East Taylor, Pa. 21. Signatura of Funaral Sarvice Licensaa 22. Name and Address of Facility
Stallings Funeral Home Pa 3111 Mountain Rd. Pasadena, Md. 21122 23a. Part1. Entar the disaese, or complete lons that shock, or haart feilura. List only one hause of Approximate Intarval Batween Onset end Death caused the daath. Do not enter the mode of dying, such es cardiac or raspiretory errast, aach lina. Physician /Medical Immediata Causa (Finel disaasa or condition resulting in death) Septic Shock 1 day Examiner Whipple Procedure

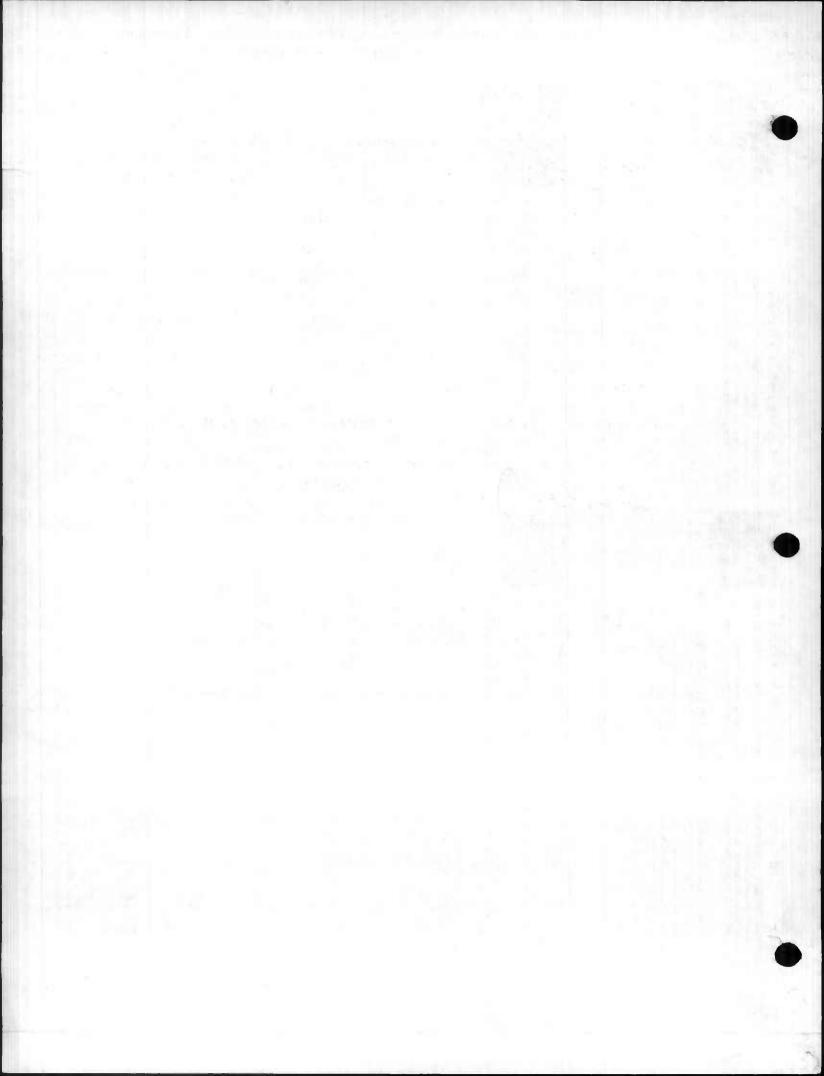
Dua to (or as a consequence of): Examiner attending physician and for use as the bunal-transit Sequantially list conditions, if any, leading to immadiate causa. Enter Undarlying Cause (Disaasa or injury that initiated evants rasulting in daath) Last Box 68760, Pancreatic months certificate be Physician/Medical Dua to (or as a consaquence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. the 23b. Dld tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown none Division of Vital Records, b 24b. Were autopsy findings evellable prior to complation of causa of daath? Completed 24a. Was en autopsy certificate has 2 1 No 1 ☐ Yes 2 Z No 1 Yas after death.

Director: After this certific 25. Was casa rafarrad to medical examinar? Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) P 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death Medical Certification: 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Natural 5 Pending invastigation 1 Yas 2 No 2 Accident none 6 Could not ba datamined 3 ☐ Suicide 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Hospital 29a. Cartifiar 12 Certifying Physician: To the bast of my knowledga, death occurred at the time, data and place, and dua to the cause(s) and mannar es statad. (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and manner stated. To the within 2 29b. Signatura and titla of certifier 29d. Date signad (Month, Day, Year) RES-000 January 26. 30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) North Wolfe Street Baltimore MD 21287-9106 Morgan Howland 600 31. Deta filed (Month, Day, Yeer)

State Registrar

JAN 28 1998

32. Registrar's Signature
Julia Navidson-Randalle



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Daath 1. Dacadant's Nama (First, Middle, Last) 3. Time of Death Month 3:05 pm MIRIAM L. BAKER 26 26 98 4c. County of Death Jan 4b. City. Town, or Location of Daeth 4a. Facility Nema (If not institution, give street and number) Catoniville Baltimonl Charlestown Care Center If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Yaar Birthplaca (State or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. iast birthday) Months Days 1□M 20 F 214-01-2281 84 Yrs 1/24/1914 MARYLAND Usual Rasidance of Dacedant 10a. State 10b. County 10c. City, Town or Location 10d. inslda City Limits 1 Yas 2 No MARYLAND HOWARD ELLICOTT CITY 10g. Citizen of What Country? 10e. Street and Numbar 10f. Zip Code U.S.A. 21043 3113 THE OAKS ROAD Race - American indien, Bleck, Whita, atc. 12. Wes Decedent Evar in U,S. Armed Forcas? Was Decadant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Ricen, atc.) 11. Marital Status 1 ☐ Yas 2 ☑ No If Yas, Give ☐ Yaar or Dates: 1 ☐ Never Merried 2 ☐ Married 1 Yas 2 No Specify: Specify: WHITE 3 Widowad 4 ☐ Divorced 16a. Dacedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) Collaga (1-4or 5+) OWN HOME HOMEMAKER 18. Mothar's Nama (First, Middla, Maiden Surname) 17. Fathar's Nama (First, Middle, Last) ALBERT C. BETZ ALMA E. DILL 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 PRIMROSE COURT, BALTIMORE, MARYLAND 21234 FRANK DAVID BAKER, SON 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 XBurial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 1/31/98 BALTIMORE, MARYLAND LOUDON PARK CEMETERY 21. Signatura of Funarai Sarvice Licensae 22. Nama and Addrass of Facility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 Kenner 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervel Batwean Onsat and Death immedieta Causa (Final diseasa or condition rasulting in daath) TEar Stage Dua to (or es e consaquance of): Dua to (or as a consaquance of): Due to (or es e consequence of) 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? 1 Yes 2 No 1 Yes 2 No 26. Piaca of Daath (Check only one)

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Important: If Item 27 is marked other any linjury or other traumatic event 2008.

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

e filed within 72 hours after all Hygiene. other than "natural", or ite

Baltimore, Maryland 21215-0020

Director

Funeral

à

Completed

Be 2

Examiner

signed by the attending physician and d be deteched for use as the buriel-transit Physician/Medical þ Completed peen : certificete Be 10 After this Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral process.

Division of Vital Records, P.O. Box 68760

requires that the death certificate be

or Attending Physician:

Registrar

(Check only one)

29b. Signatura and titla of certifiar

Sequantielly list conditions, if any, laading to Immadiate ceusa. Entar Undarlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Parkinson's Disense 25. Wes case referred to medical axaminar? Hospital: 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 28a. Data of injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Time of 28c. injury et Work? 1 Naturai 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarminad 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homlcida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29a. Cartifiar Medical

29c. Licensa number

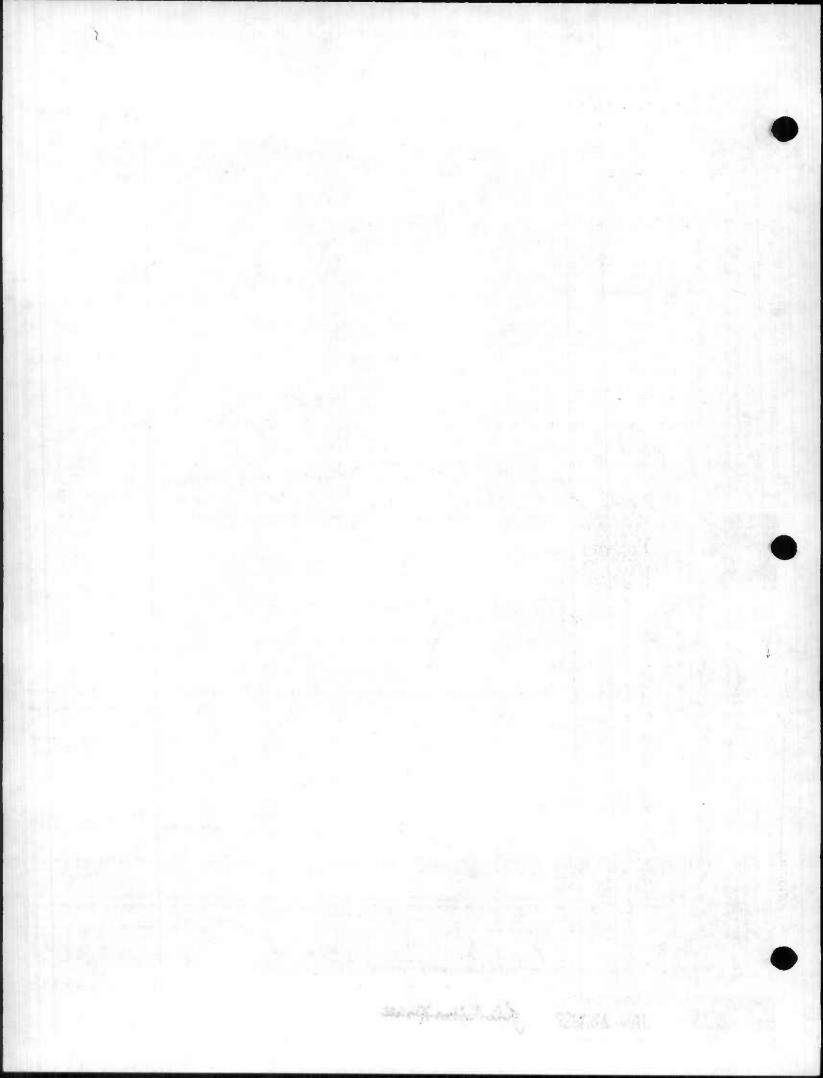
1) 5105/

29d. Data signed (Month, Day, Year)

January 26 1998

7/1 Maiden choice lane, contousville, MD, 21228 Andres Salazar 31. Dete filed (Month, Day, Year) JAN 28 1998

30. Nama and address of person who completed causa of death (Itam 23a) (Type, Print)



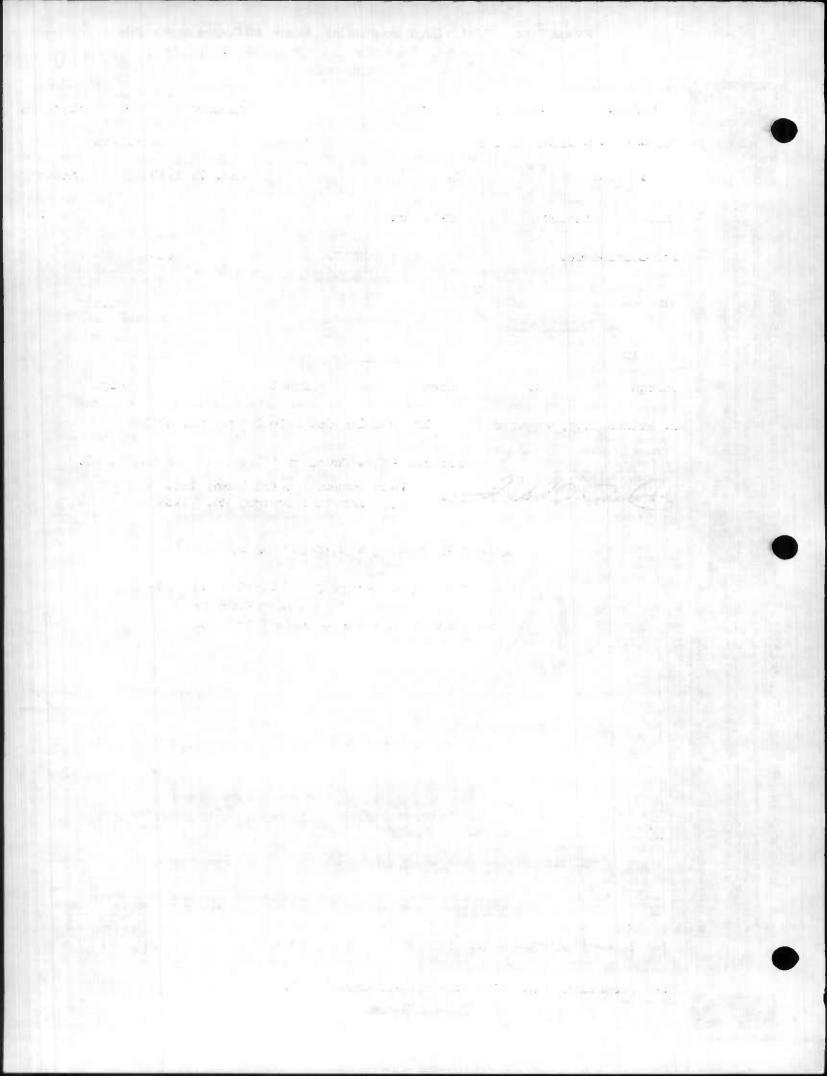
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month Day Year **Physician** WALTER CREE 26, 1998 11:48 PM GEORGE January /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner St. Joseph Medical Center Baltimore Towson 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dev. Year) **Funeral** Deys Months 1 € M 2 □ F Hours Director 216-54-3569 80 Jan. 7, 1918 Canada Usual Residence of Deceden with the Marylend 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County r 28a-f show a notified at show 1 ☐ Yes 2 No Fl. Flagler Palm Coast Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or items 23s or 122 Cochise Ct. 32137 IISA 8 deeth Funer 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Maritel Status Bleck, White, etc. filed within 72 hours efter 1 Yas 2 No
If Yes, Give
Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 St No Specify: by 3 ₺ Widowed 4 Divorced Completed h end Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use ratired) University of Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 Maryland Purchasing Agent 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Pages 1 and 2 should be fill ment of Heelth end Mental Hant: If Item 27 is marked oth ury or other traumatic even Be Cree Ethe1 Leigh George A. 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 122 Cochise Ct. Palm Coast, Fl. 32137 Ms. Arlene Cree/daughter Baltimore. 20b. Piece of Disposition (Name of cemetery, crametory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removel from State Depertment c important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) Flagler Palms Cemetery 1/30/98 Bunnell, Fl. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee L. 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset end Deeth **Physician** * CUTE MYO CARDIAL INFAPETION /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): ARTERIOSCLEPOTIC HEAPT DISEASE. Examiner and i-transit the death certificate be executed Due to (or es e consequence of): (HPREMENSION) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest physician are the burief-t ISCHEMIC CAPRID MYOPATHY Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of) ettending pl signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Onknown by 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? 24e. Wes en eutopsy Completed certificate has lifector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: effer death. Director: After this certific director 25. Wes case referred to medical Be 26. Piece of Death (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 3 4 Homicide 24 hours efter Funeral Dire letely filled in b 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es stated. edicai completely 2 Medical Examiner: On the basis of examination end/or invastigetion, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner steted. (Check only one) To the To the To the 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 8. Mr U 0397 30. Name end address of person who completed causa of deeth (Item 23a) (Type, Print) 9506 Harford Rd. Carney, Md. Ruben Sebastian, M.D. 31. Dete filed (Month, Day, Year) 32. Jegistrer's Signature

July Davidson Randall State 28 1998 JAN

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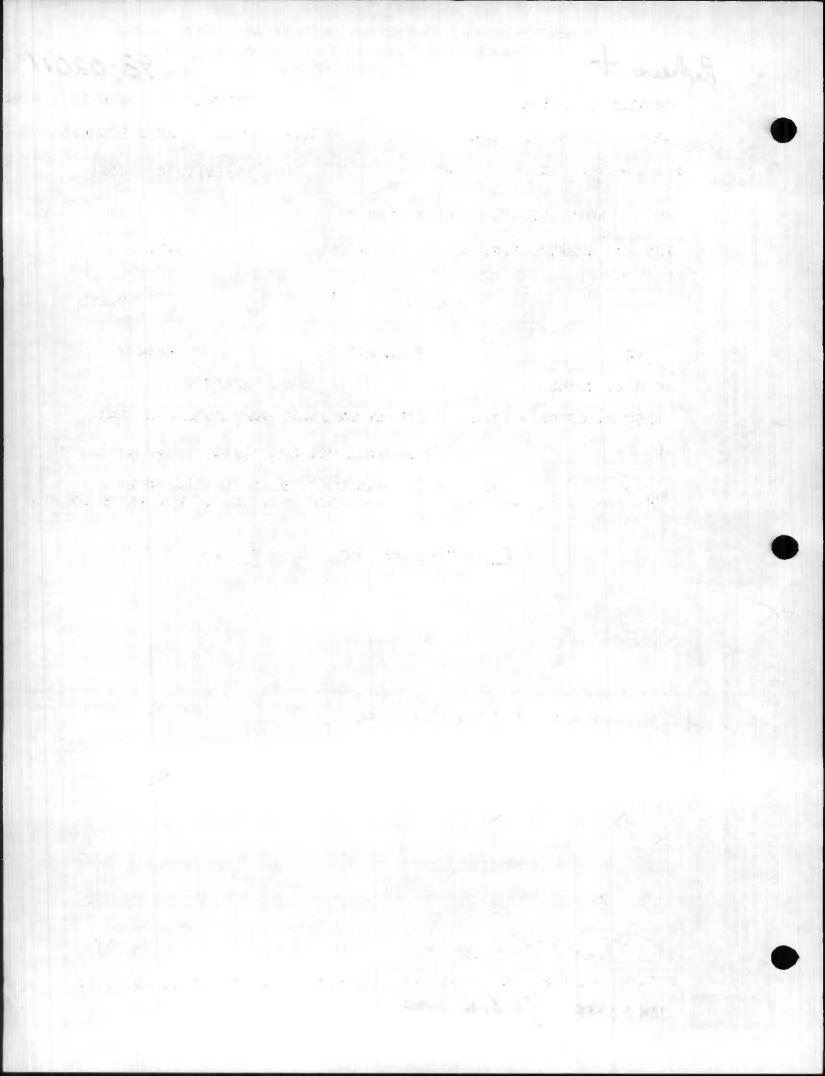


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Daath 1. Decedant's Nama (First, Middla, Last) 6:45 P.M JANUARY TI, 1998 Physician CHARLES D. COYNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva straat and number) Examiner ANNE ARUNDEL GLEN BURNIE NORTH ARUNDEL HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | 9/29/1928 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign
Country) **Funeral XX**M 2□ F 69 Yrs. 484-22-3992 IOWA Director Usual Rasidance of Decedant permit. Peges 1 and 2 should be filed within 72 hours eftar death with the Marylend Department of Haalth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinations in an item of the notified. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits GLEN BURNIE MD ANNE ARUNDEL 1 ☐ Yas XXNo Directo 10e. Street and Number 10f. Zip Coda 10g. Citlzen of What Country? U.S.A. 21061 201 6TH AVENUE, S.E. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status XXYas 2 □ No If Yas, Giva Yaar or Datas: WWII 1 Navar Marriad & Married altimore, Maryland 21215-0020 1 ☐ Yas 2 X Xo Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) PIPE FITTER FACTORY 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) CLEO KELLEY JOHN F. COYNE 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Nama/Ralationship (Type, Print) ALICE M. COYNE - WIFE 201 6TH AVE., S.E., GLEN BURNIE, MD 21061 20b. Place of Disposition (Nama of Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 █ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata CROWNSVILLE VET CEM 1/15 CROWNSVILLE, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility
RAYMOND C. FINK FUNERAL HOME 21. Signature of Fuheral Service Licensee 426 CRAIN HWY., S.W. GLEN BURNIE, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Daath **Physician** the liver Immediata Causa (Final disaasa or condition rasulting in daath) /Medical irchosis **Examiner** Dua to (or as a consequence of) Examiner physician and the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 8 Physician/Medical Dua to (or as a consaquance of): The law requires that the death certificate ettending pl for use as t signed by the e 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 25 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy periormed? complation of causa of daath? s certificata has b 210 No 1 ☐ Yas 2 ☐ No I or Attending Physician: after death. Director: After this certifica 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 280 No Certification: To 1 Yas 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 27. Mannar of Daath funerel 28d. Dascriba how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 2 Accidant 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) in by 4 Homicida To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifian (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licansa number 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) NEIL E. PADGETT, MD 7711 QUARTERFIELD RD. GLEN BURNIE MD 21061

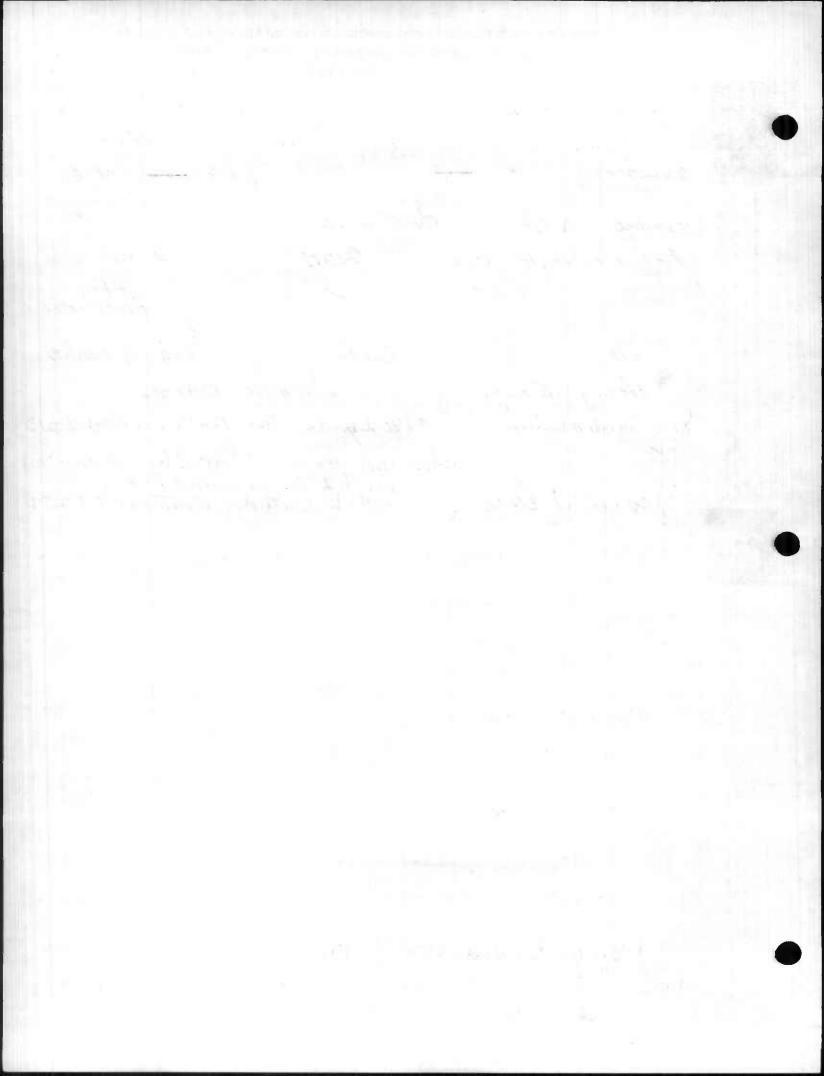
DHMH 16 Rev 6/95

Registrar

31. Data filed (Month, Day, Year)
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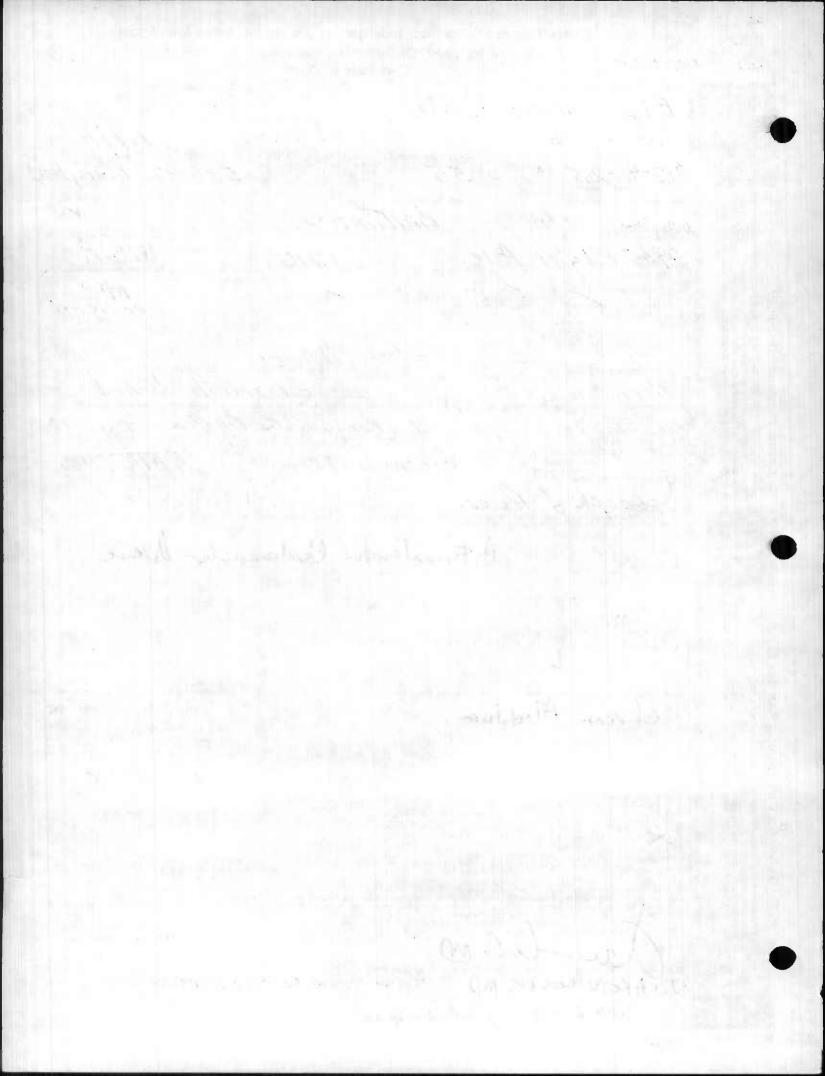


	B.K.S EDGAR H	ARI		tate of Maryland /		f Health and		giene) 8	02013
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) Edgar Harri 4e Fecility Name (If not Institution, give stre	s Carte	Y	4b. City, Town, or	2. Dete of De Month JAN. Location of Deal	9,1998	Yeer 3. Time of Deeth 0933 AM of Deeth
	Examin Funeral Director	er	2905 ELGIN AVENUE 5. Social Security Number 2/2-441-20.55 10 M	7. Age (In yrs. lest)	oirthday) If Under 1 Ye Months De	BALTIM ear If Under 24 Hrs	ORE 8. Date of Bi	rth /	9. Birthplece (State or Foreign County)
		tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location	re		0 100	10d. Inside City Limits 1 Yes 2 No
020	72 hours efter deeth with the Maryland natural; or items 23s or 28s-f show does Examiner must be notified a	by Funeral Director	1 Never Merried 2 Married	Wes Decedent Ever in U,S. Armed Forces? 1 ETYes 2 \(\) No If Yes, Give Year or Dates:	13. Was Decedent If Yes, specify 0	of Hispenic Origin? (S Cuben, Mexicen, Puer	Specify Yes or N to Rican, etc.)		Vhet Country? S. American Indien, k, Winter, etc.
121215-0020	swithin jiana. r than	Completed t	15. Decedent's Educeti (Specify only highest grade co		e. Decedent's Usual Oc (Give kind of work do life. DO NOT use re	manger	/	16b. Kind of Bu	Sales
Maryland	should be nd Mantel marked o	To Be	17. Father's Name (First, Middle, Last) 19e. Informant's Neme/Relationship (Type,	Print) CSister) 1	9b. Mailing Address (Str	Eliz	abeth	ber, City or Town,	ard
Baltimore, M	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra pace.		20e. Method of Disposition 1 Burial 2 2 Cremetion 3 Rem 4 Donetion 5 Other (Specify) 21. Separature of Funeral Servica Licansee	Coper 20b. Placa come Green State	of Disposition (Name of otery, cremetory or other COMOUN) 32. Name end Ac	T Cem Idrass Pacifity 5	Jogg FLENE, Ave. To	BALLO.	City or Town, Stete md md md md 21216
	Physician /Medical Examiner	er.	Part1. Enter the disease, or complicate hock, or heaft failure. List only one of timediate Ceuse (Final disease or condition resulting in death)	Ateris:	denter the mode of	dying, such es cárdia		Λ	Approximete Intervel Between Onset end Death
x 68760,	death cartificate be executed e ettanding physician end od for use es the bunel-transit	/Medical Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest		e consequence of):				
, P.O. Box	the school	by Physician/Med	Part II. Other eignificant conditions contrib	uting to death but not resulting	in the underlying cause	e given in Pert I.		I tobacco use cor] Yes 2 □ No	ntribute to the cause of death?
Records,	e law requir hes been s ge 2 should	Completed b					per	s en eutopsy formed?	24b. Were eutopsy findings evailable prior to completion of cause of deeth?
of Vital	Physician: r this certific iral director,	To Be		8e. Dete of Injury 28t	Outpetient 3 DOA	Other:	1	one) sidence 6 Oth	
Division	l or Attending I after death. Director: After I in by the funer	Certification:	2 Accident 3 Suicide 4 Homicide S Pending investigation Could not be determined	(Month, Dey Year) 18e. Place of Injury - At home, building, etc. (Specify)	М	1 ☐ Yes 2 ☐ No	28f. Location City or To	(Street and Numb own, State)	er or Rural Route Number,
	To the Hospital or Attandii within 24 hours after death. To the Funeral Director: A complately filled in by the fu	Medical C	(Checker) Medical Examiner:	on: To the best of my knowled On the besis of exeminetion end menner steted.	end/or Investigation, in r	ne time, date end plec ny opinion, deeth occ cense number	e, end due to the urred et the time	, date end place,	anner es steled. and due to the ceuse(s) d (Month, Dey, Year)
)	5 × 5 8		29b. Signation and title of certifier 30. Name and appress of person who comp	urlem	0.	C.ME			, 1998

State

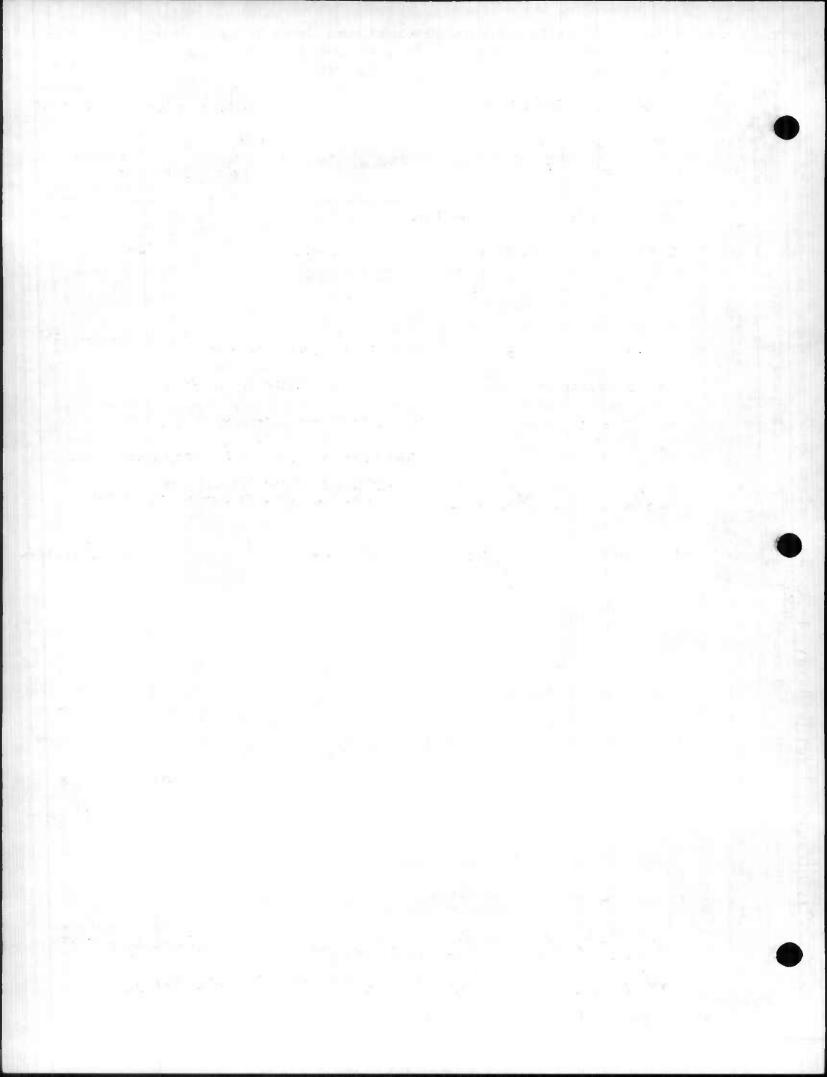
Registrar

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene ()

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	, Mary and 2 sho selth end N 127 is ma er traume		19a. Informant's Na Vera Pa					-					er, City or Town		Coda)	
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JAC.	C g g	ation	1 XNaturel 2 Accident	5 Pending invastigatio	28a. Data of I (Month,	Day Year)	Injury		28c. Inje We	ork? □Yes 2□N		200. Dascriba	now injury occu	neu	V	
haritonul	DIVISION if or Attending efter death. Director: Afte	Certification:	3 ☐ Sulcide 4 ☐ Homicida	6 Could not be determined	200. Piece of	Injury - At h	nome, farm,	straat, facto	ory, office	•		28f. Location (City or To	Street and Num wn, State)	bar or Rura	al Routa Number,	
2	DIVISIO To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the f	edicai C	29a. Certifiar (Check only one)	CertifyIng Pt	ysician: To the ba niner: On the basis and mannar	s of examin	owledge, da etion end/or	eth occurra Invastigation	d at the t	time, date end opinion, daati	place,	and dua to the ed et tha tima,	ceuse(s) end m deta and place	enner as s , and due to	tatad. o the cause(s)	
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	10		30. Nama and addre	ss of person who	completed causes	of death the	m 23a) (Typ	a, Print)	060	/ N.	ch	arles	SHE	et	17, 1998	
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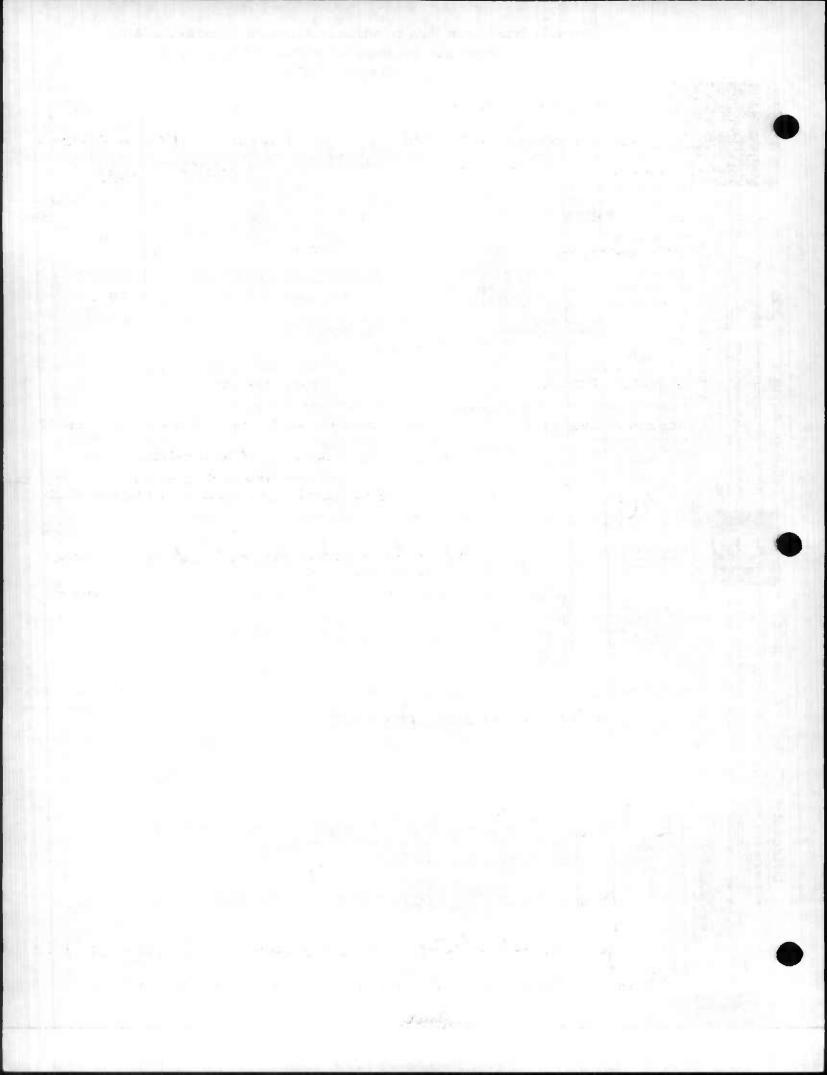


State of Maryland / Department of Health and Mental Hygiene (Certificate of Death Item: 3 per Physician G-755 1/28/98 reb 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** ANNA MAY CARROLL 20, JANUARY 1998 9:07 P.M /Medical 4b. City, Town, or Location of Deeth CATONSVILLE 4e. Fecility Neme (If not Institution, give street end number) 1908 FREDERICK ROAD Examiner BALTIMORE 5. Sociei Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth 9. Birthplace (Ste NOV. 25, 1914 MARYLAND 7. Age (In yrs. lest birthday) 9. Birthpiace (Stete or Foreign **Funeral** 1 M ADF Deys Hours Yrs Director 214-12-1592 Usuel Rasidence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mental Hygiene. Important: If Nem 27 is marked other than "natural", or Nems 28a or 28a-f show any injury or other traumetic event, the Medical Examinar reserved. 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND BALTIMORE CATONSVILLE 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1908 FREDERICK ROAD 21228 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ĀNo If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elemantary/Secondery (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) JOSEPH MANNING CHRISTINE KLINESCHMIDT 19e. tntorment's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ANN C. LANE 14317 DAIRYDALE COURT, BALDWIN, MARYLAND 21013 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 1/24/98 BROOKLYN PARK, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 22. Name and Address of Facility WITZKE FUNERAL HOMES, INC. 21. Signature of Funerel Service Licenses With. Cian 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heart teilure. List only one cause on each line. Onset and Death Physician /Medical Immediete Cause (Finai myocardial mfaration diseese or condition resulting in death) Examiner Examiner 5413 physician and s the bunei-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or trijury that initiated events resulting In death) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequenca of) is signed by the ai Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown by Completed perchalesterde inja 24b. Were autopsy findings evailabla prior to completion of cause of deeth? 24a. Wes an eutopsy performed? Penpleral Vascular Disease 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No To the Mospital or Atlanding Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, i 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28e. Deta of Injury (Month, Dey Year) 27. Mennar of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be datermined 3 Sulcide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of injury - At homa, term, street, tectory, office building, etc. (Specify) 4 - Homicide edical 1 Certifying Physician: To the best of my knowledga, daath occurred et the tima, data and piece, end dua to tha causa(s) and mannar as steted. 29e. Cartifier (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, daeth occurred at the time, data and place, end due to the cause(s) end mennar stated. 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Dey, Yeer) 1044243 January 21,1998 30. Neme end addrass of person who completed cause of deeth (itam 23e) (Type, Print) O 516 N. Rolling Rd #108 Catensville MND Z1228 JW Cook IV MO 31. Dete filed (Month, Day, Yeer) State 28 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

											Reg. No.			
Physiciar			me (First, Middle, La		1	11'				2. Date of De Month	eelh Day	Yeer 3. T	Time of Death	
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Examine	r	1	(If not institution, git are Re	gional	Hosp	sita	-1	1	1	or Location of Deet		ce Geo	orge's	
uneral irector	- 1	5. Social Security 214–05–3	Number 6.		7. Age (In yrs	s. last birt		der 1 Year ns Deys	If Under 24 H		th ay, Year)	9. Birthplace (Country) Italy		
	- 1	Usual Residence	_							J-17-1.	703	Italy		
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23a or	=	10e. Street and N 11805 Wa	yneridge				101. 2	Zip Code 2	0759		10g. Citizen of USA			
1 1 1	6		rried 2 Married	12. Was Dece Armed For 1 Yes If Yes, Give Year or Da	ces? 2 X No e	U,S.		cedent of H pecify Cuba 2 X No		(Specify Yes or No erto Rican, etc.)		ce - American Inc ck, White, etc. y: White	lian,	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 8 PM Anna J. Dolan Jan. 23, 1998 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth 6242 Patuxant Quarters Road Elkridge Howard County If Under 1 Year If Under 24 Hrs. Nonths Deys Hours Min. Dec 26, 1917 Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M ADV Yrs. 213-05-0558 80 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Wes 2□No Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3838 Roland Avenue 21211 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 N Widowed 4 □ Divorced white Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry

Meat Packer

Food Mfgr.

18. Mother's Neme (First, Middle, Maiden Sumeme)

Elizabeth Darby

traumatic evant, the Medical Examiner must be notified at 72 hours after altimore, Maryland 21215-0020 "naturel". filed within permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If flam 27 is merked other than any injury or other trainment.

Physician

/Medicai

Examiner

10a. State

Elementery/Secondary (0-12)

17. Fether's Neme (First, Middle, Last)

William Parrish

College (1-4or 5+)

Funeral

Director

28a-f show

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items 23a

6

Director

Funeral

by

Completed

Be

2

the Maryland

Physician /Medical Examiner

burial-transit signed by t certificate has After this death. Director: in by

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

or Attending Physician:

the

19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Ann Conrad Daughter 6242 Patuxant Quarters Rd Elkridge, MD 21076 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 N Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Lorraine Park Cem. 1/27/98 Woodlawn, Maryland 22. Name end Address of Fecility 21. Signature of Funeral Service Ucenses Burgee-Henss Funeral Home, PA ter the divisite or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, MESPSTOTIC PECTES Concer Immediate Ceuse (Final disease or condition resulting in death) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initioted events resulting in death) Lest Due to (or es e consequence of): Physician/Medicai Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Completed 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 2 12 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only the) Other: 4 Nursing Home 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 5 Desidence 6 □Other (Specify) 27. Manne Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Waturel 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide edical 1 Certifying Phyelcien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

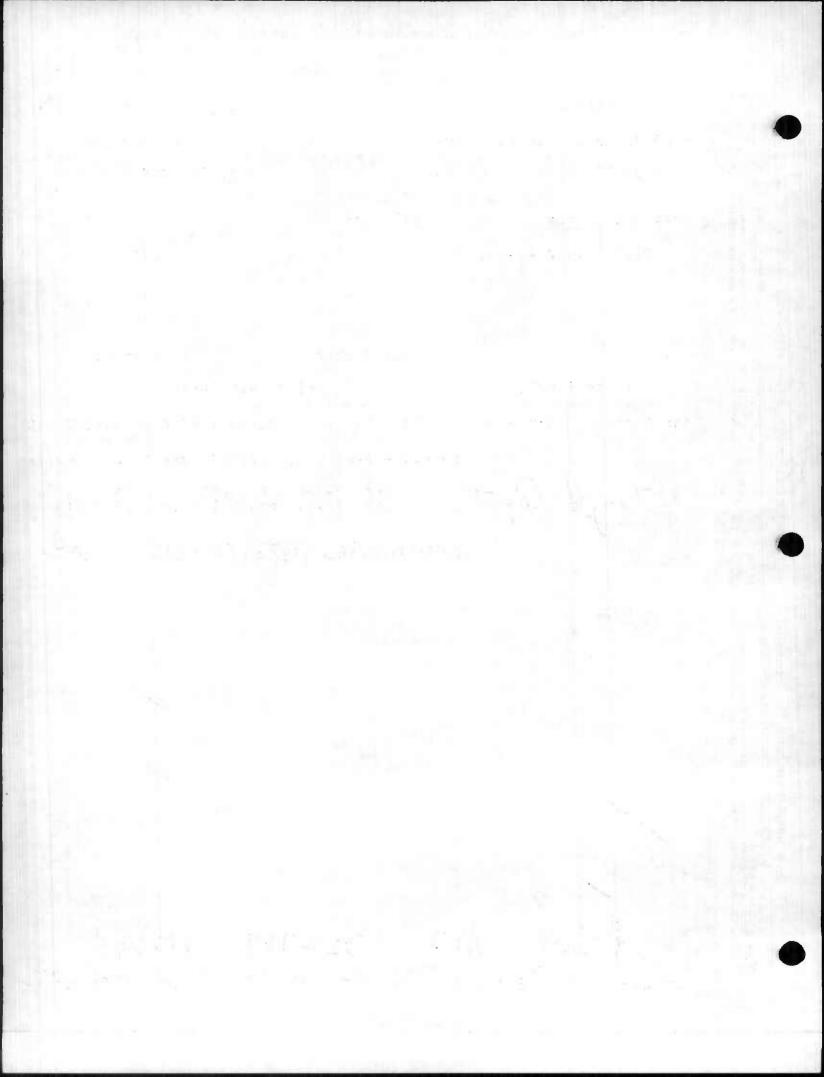
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signature end 10 of or 29d. Date signed (Month, Dey, Year) 29c. License number 30. Name end eddress of person TUDES

State Registrar

31. Date filed (Month, Day, Year)

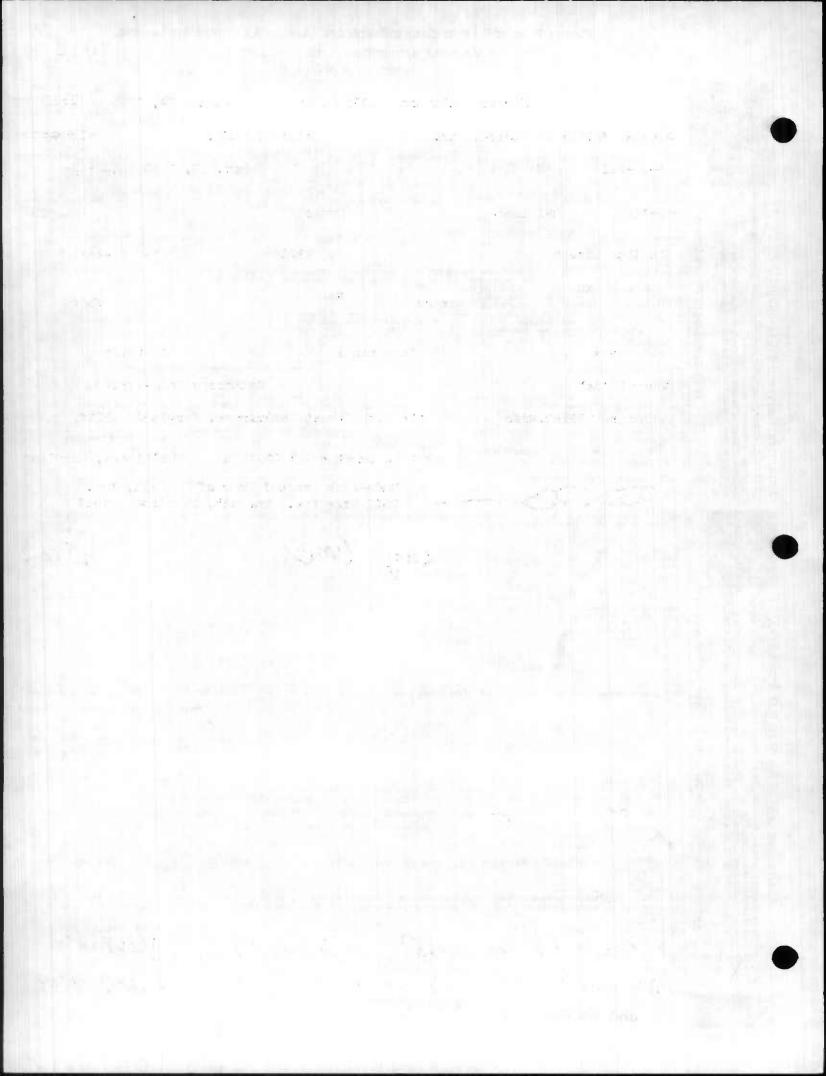
32. Registrar's Signeture

within 24 hours efter of To the Funeral Direct completely filled in by



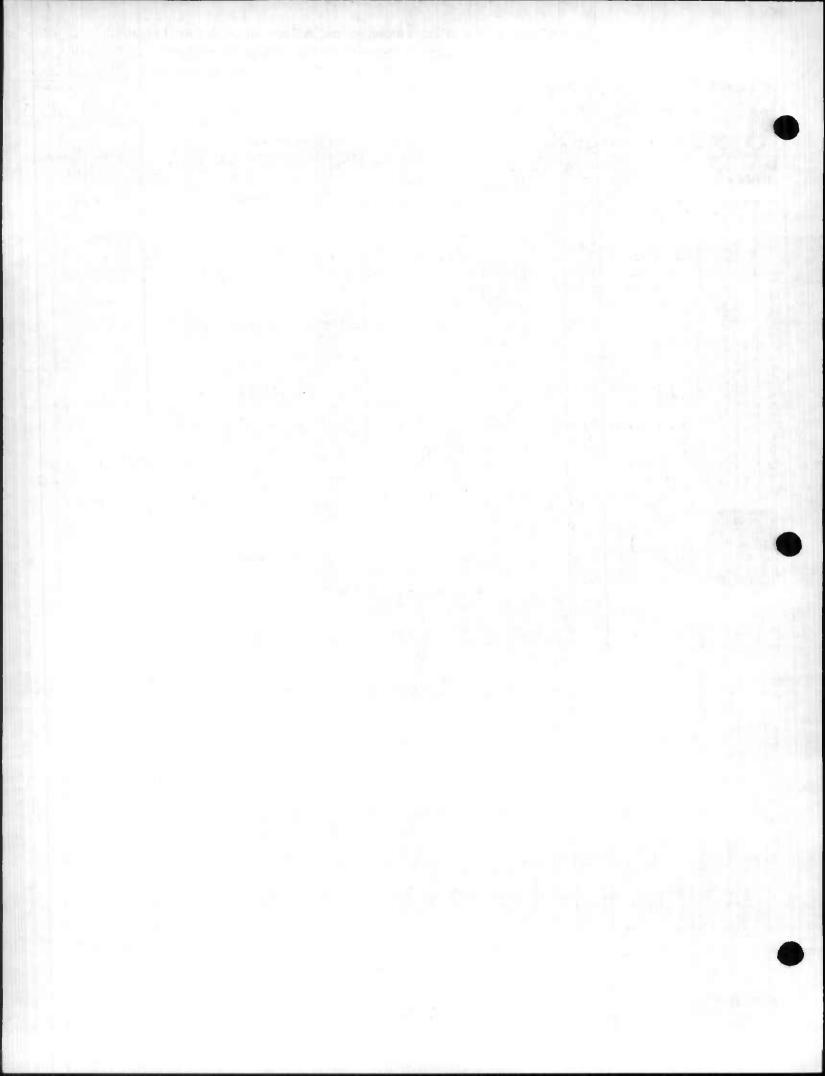
State of Maryland / Department of Health and Mental Hygiene 8 020 8

				Certific	cate of	Death			Reg. No.		
Physician /Medical	Decedent's Name (First, Mide	e, Last) Edwar	d Stewa	rt E	llick,			2. Dete of De Januar	eth Y 24, 1	.998	3. Time of Death 2:12 PM
Examiner	4e Fecility Neme (If not institution Greater Balti					Balti	more	CO.	4c. County	В	altimore
Funeral Director	5. Social Security Number 215–30–3892	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. last bi		Inder 1 Year oths Days	If Under Hours	Min.	8. Dete of Bird (Month, Pa	Y. Year) 1933	9. Birthp Coun Mary	lace (Stete or Foreign try) /land
death with the Maryland rms 23a or 28a-f show rms to cour ed.	Usual Residence of Decedent 10a. State 10b. Count Maryland	y Baltimore	10c. City, Tow	m or Location		ıdalk				1	0d. Inside City Limits 1 ☐ Yes 2XXNo
23e or 28 unt be not	10e. Street end Number 618 47th Stre	et		10	f. Zip Code	2122	:4		10g. Citizen of United		
or, or its	11. Meritel Status 1 □ Never Married 2∑Ma 3 □ Widowed 4 □ Divorce	rried Armed Fo	2 No	If Yes	Decedent of it, specify Cub	en, Mexicar	n, Puerto F	cify Yes or No Rican, etc.)		ce - Americ ck, White,	
led within 72 hours lygiene. her than "naturel", rt, me Med cal Ext Completed by	15. Decede	nt's Education est grede completed)	16e	(Give kind)	Usuel Occup of work done	during mos	at of workin	g	16b. Kind of B	usiness/inc	dustry
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1 and 2 should be Health and Mental am 27 is marked of other traumatic ev	19e. Informent's Name/Relation Catherine Ell			_					er, City or Town laryland		
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permit. Pages Department of Important: If it sny injury or o	21. Signeture of Funerel Service	Licansee	0	Duda		Funer	cal Ho		Dundall Maryland		c. 222
Physician /Medical Examiner	23a. Pert1. Enter the disease, shock, or heart feilure. Lis Immediate Ceuse (Finel disease or condition resulting in deeth)	e.	Due to (or es e	unj	Car	ncel	cardiec of	Tesphetory e	11031,		Approximate Interval Between Onset end Deeth
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been sign should be								24e. Wes	en eutopsy ormed?	24b. We	ere eutopsy findings eilable prior to mpletion of cause deeth?
The law ate has by page 2 s								1 🗆	Yes 2000		☐Yes 2☐ No
entific ector.	25. Wes case referred to medic exeminer?	al Hospitel: 🙏			Ott	hor:		(Check only o			
To the Mospital or Attending Physis within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors. Medical Certification: To	1 Yes 2 No 27. Manner of Deeth Naturel 5 Pend 2 Accident inves 3 Suicide 6 Could	ing 28e. Dete (Mon	th, Dey Year)	Time of Injury	28c. Inju Wo	4 🗆 N	No 2	8d. Describe	denca 6 Oth	rred	al Route Number,
pital or A sura after sral Direc filled in by	4 Homicide deter	mined 288. Place build	e of Injury - At home, fing, etc. (Specify)			mo data		City or To	wn, State)		
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State Registrar	31. Dete filed (Month, Dey, Year JAN 281	998	Register Statute	Janaabl			ė l				,



State of Maryland / Department of Health and Mental Hygiene

Physician		A David Market Control of the Asset of the A			Cert	ificate d	of Death	1	Reg. No.	021	119
	_	1. Decedent's Name (First, Middla, La						2. Data of D Month	Day	Yaar	Tima of Death
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Examiner	r ľ	le. Facility Nama (If not institution, gi					4b. City, Town, o				
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uneral irector			Sax 7. A	ga (In yrs. I	ast birthday) Yrs.	Months De			irth Pay, Year) -/9/0	9. Birthplaca Country)	(Stata or Foreign
* W	-	10a. Stata 10b. County		10c. City	, Town or Loca	ation				10d. I	Insida City Limits
	2	Md NA		8	altin	none					Yas 2□No
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"naturel", edical Ex leted by		15. Decedant's E (Spacify only highast gr	ducation		16a. Deceda	nt's Usual Oc	cupation ona during most of wi tired)	orkina	16b. Kind of B	usin ass/Indus tr	у
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or other treumstic event, the Medical. To Be Completed		John B. Matn	ey				Marga	/ 0	own		
E E		19a. Informant's Name/Ralationship	Type, Print)	•	19b. Mailing	Addrass (St	aat and Number or F	Rural Routa Num	ber, City or Town,	Stata, Zip Coo	(e) 2322
item 27 other tr		haverne Sourle	ock -Nie	ce	1611	Fore	ot Glen	Road	Kighn	rond, L	la
a de	2	20a. Mathod of Disposition	75	20b. PI	ace of Disposi matary, crema	tion (Nama o	f placeh	Data	20c. Location -	City or Town,	Stata
Important: If any injury or once.		1 Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Specia	JRamoval from Stata v)	Ar	hutus	MON	Uniti	1-28-98	Arbut	us. Ma	/
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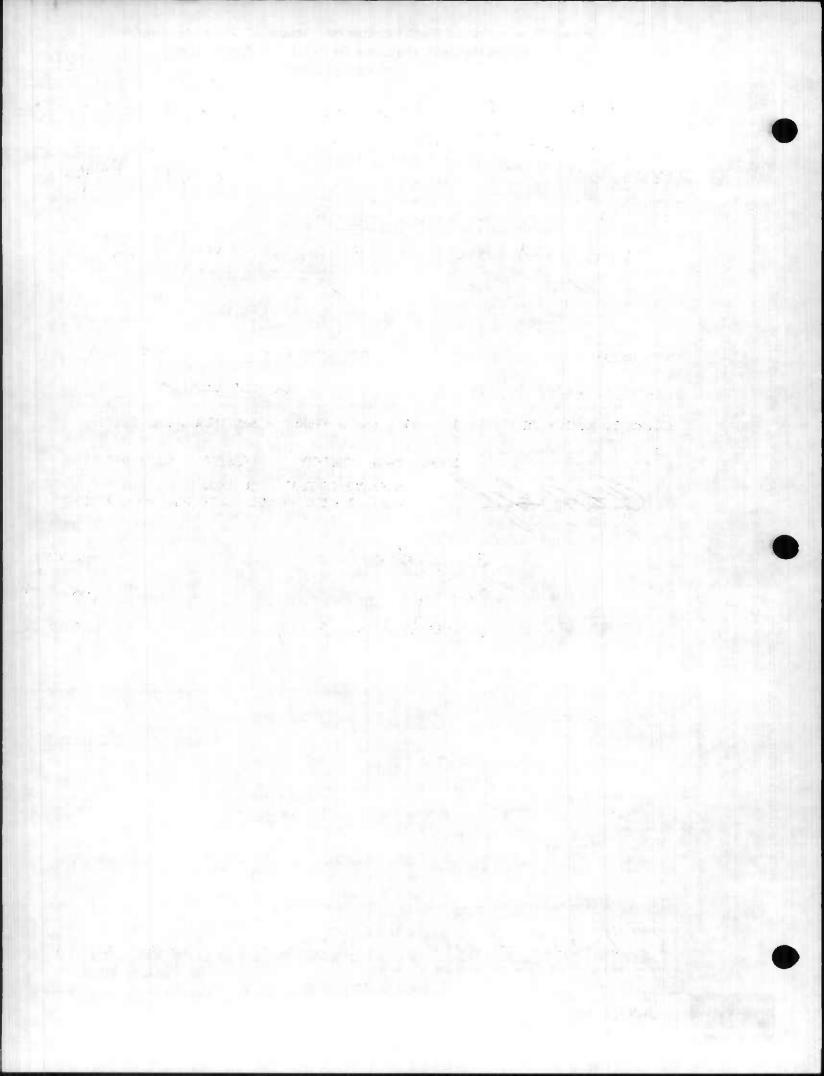


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Da Yaar **Physician** 4:35 am 4b. City, Town, or Location of Death 22 1998 -mric /Medical 4c. County of Death 4a Facility Name (If not institution, giva street and number) **Examiner** Baltimore Rehab ANS9 Baltimore
If Under 24 Hrs. 8. Date of Bir Elizabeth If Under 1 Yaar 9. Birthplace (State or Foreign Quantry) 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sax 1 M 2 F **Funeral** Min Months Days Hours Jary wind 9559 21809 955 Usual Residence of Decedent Yrs. 79 Director the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Nem 27 is marked other than "natural", or Rems 23e or 28e-f show other traumatic event, the Madical Examiner must be notified at Maryland 1 ☐ Yes 2 No Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with Bal Ave 21229 USA ceds timore permit. Peges 1 and 2 should be filed within 72 hours effer death a Department of Heelth and Mentel Hygiene. Important: if flem 27 is merked other than "natural", or items 234 any Injury or other traumetic event. It a Merical Contract of the contract of the Merical Contract of the Cont Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: 14. Race - American Indian, 11. Marital Status Black, Whita, atc 1 Never Married 2 Married 1 Yes 2 No specify: White Baltimore, Maryland 21215-0020 Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highast grade completed) Etementery/Secondary (0-12) College (1-4or 5+) Homemaker HOMEMAKING 12TH GRADE 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Nama (First, Middla, Last) Be 10 RICHARD LAUR CAROLINE POTTHAST 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4410 LEEDS AVENUE - BALITMORE, MD ROBERT E. EMRICH, SR (HUSBAND) 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1/26/98 4 ☐ Donetion 5 ☐ Other (Specify) LOUDON PARK CEMETERY BALTIMORE 22. Name and Address of Facility
HUBBARD FUNERAL HOME INC. 21. Signature of Fugural Service Licen 21229 4107 WILKENS AVENUE-BALTIMORE, MD Approximate interval Between Onset and Death 23a. Part1. Enter the disease, or complications at caused the death. Do not enter tha moda of dylng, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ach tine. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner sician end buriel-transit sphadia be executed Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of): ettending physician for use es the burie Box 68760 Deendo Da Physician/Medical Dua to (or as a consequanca of) certificete signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown dementa 20 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peed page 2 hes 20100 1 ☐ Yes 2 ☑ No 1 ☐ Yes certificate Attending Physician: funeral director, Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Yaar) 28d. Describe how Injury occurred 28b. Time of or Attending P. efter deeth. Certification: 28c. Injury at Work? 1 DNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end ptece, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and little of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) anham 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 28 1998 ma laurdson-yandelle Registrar



State of Maryland / Department of Health and Mental Hygiene 0 0 0 0 0 1

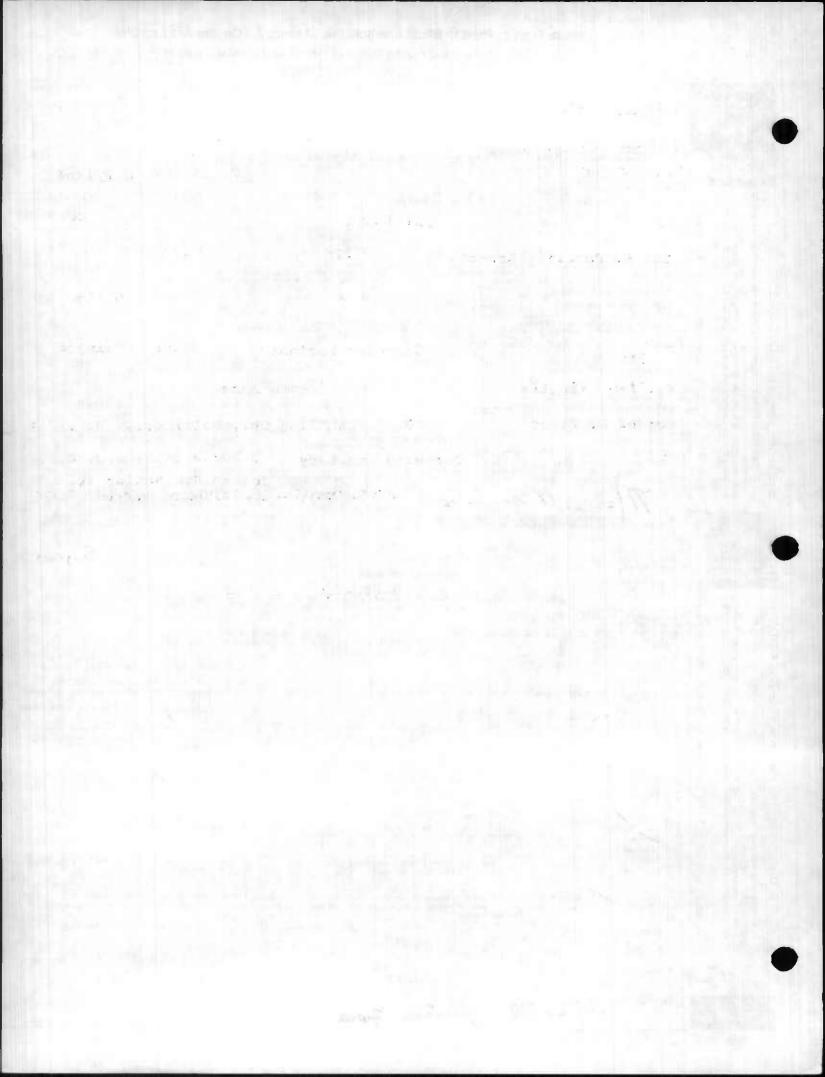
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Examin	er	4e. Fecility Neme (If not institution, gla		10-1	- 41	or Location of Deeth	4c. County of	1
Consend	-	5. Social Security Number 6.5	BOYVIEW Med Sex 7. Age (In yrs.		der 1 Year If Under 24 H		Baltimo	
Funeral Director		212-16-3409 Usual Residence of Decedent	1□м 2Д г	87 Yrs. Month	s Deys Hours M	8. Date of Birth (Month, Dey,	Yeer)	9. Birthplece (Stete or Foreign Country) Maryland
show ad at		10e. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
28a-f sho	cto	laryland Balti	more Du	ndalk				1 XYes 2 □ No
23a or	Funeral Director	101 Centre	Place # 50	2 106.	Zip Code 122	11	og. Citizen of What $4.5A$	net Country?
Items Per m	nue	11. Marltel Status	12. Wes Decedent Ever in U Armed Forces?	,S. 13. Was De	cedent of Hispenic Origin? pecify Cuben, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		- American Indian, , White, etc.
òE	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 □ Yes	2 No Specify:		Specify:	Black
"neturel",	Completed	15. Decedent's E (Specify only highest gro	ducation ede completed)	16a. Decadent's U	work done during most of v	vorking	6b. Kind of Bus	iness/Industry
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t of Health and Mentel Hygiene. If Item 27 is marked other than or other traumatic event, the M	To Be	Trum soud Parl	l po		Dais	2.	5077	,
and M is mar aumat		19a. Informent's Name/Relationship	Type, Print)	19b. Mailing Addre	ess (Street end Number or	/		itete, Zip Code)
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item 27 other tr		20e. Method of Disposition		Plece of Disposition (A	leme of	Date	Oc. Location - C	city or Town, Stete
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ysician		shock, or neert failure. List only	one ceuse on each line.					Intervel Between Onset end Death
Medical		Immediate Ceuse (Final disease or condition	Rospins	har Arr	ect			1/0/00 1/26/
aminer		resulting in deeth)	e. Due to (c	or es e consequence d	of):			110110 11201
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and trans	cam	Sequentially list conditions,		or es e consequence d	rf):			
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signed by the e	Physician/	Pert II. Other significent conditions of	contributing to death but not res	uiting in the underlying	g cause given in Pert I.	23b. Did to	bacco use conti	ribute to the cause of death?
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sign d be	d by					24e. Wes er	outenou	24b. Were eutopsy findings
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his o				Injury M	Work? 1 ☐ Yes 2 ☐ No			
		1 Netural 5 Pending Investigatio	11		ory, office	28f. Location (St	eet end Number	r or Rural Route Number,
		2 Accident Investigatio 3 Suicide 6 Could not b		ome, farm, street, fact			Stete)	
		2 Accident Investigatio	00 51 111	ome, farm, street, fact y)	,,	City or Town		
Financial death. Funeral Director: After the funeral	Certification:	2 Accident 3 Suicide 4 Homicide Investigatio 6 Could not be determined	28e. Piece of Injury - At his building, etc. (Specifing) Nyelclen: To the best of my knominer: On the besis of examine	wledge deeth occurre	ad at the time, date and pla	ce and due to the ca	use(s) and man	ner es steted. Indicate de deuse(s)
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in 24 no. — Tur doath. In Eurora Director: After ti pleon, E. — Oy the funera	edical Certification:	2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only one) Certifying Phase C	28e. Piece of Injury - At he building, etc. (Specifing Piece) and the building of the best of my known inner: On the best of examine end menner stated.	wledge, deeth occurre tion end/or investigate	ed et the time, date end pla on, in my opinion, death oc 29c. License number	ice, end due to the ca courred et the time, de	use(s) end menute end place, en	(Month, Day, Year)
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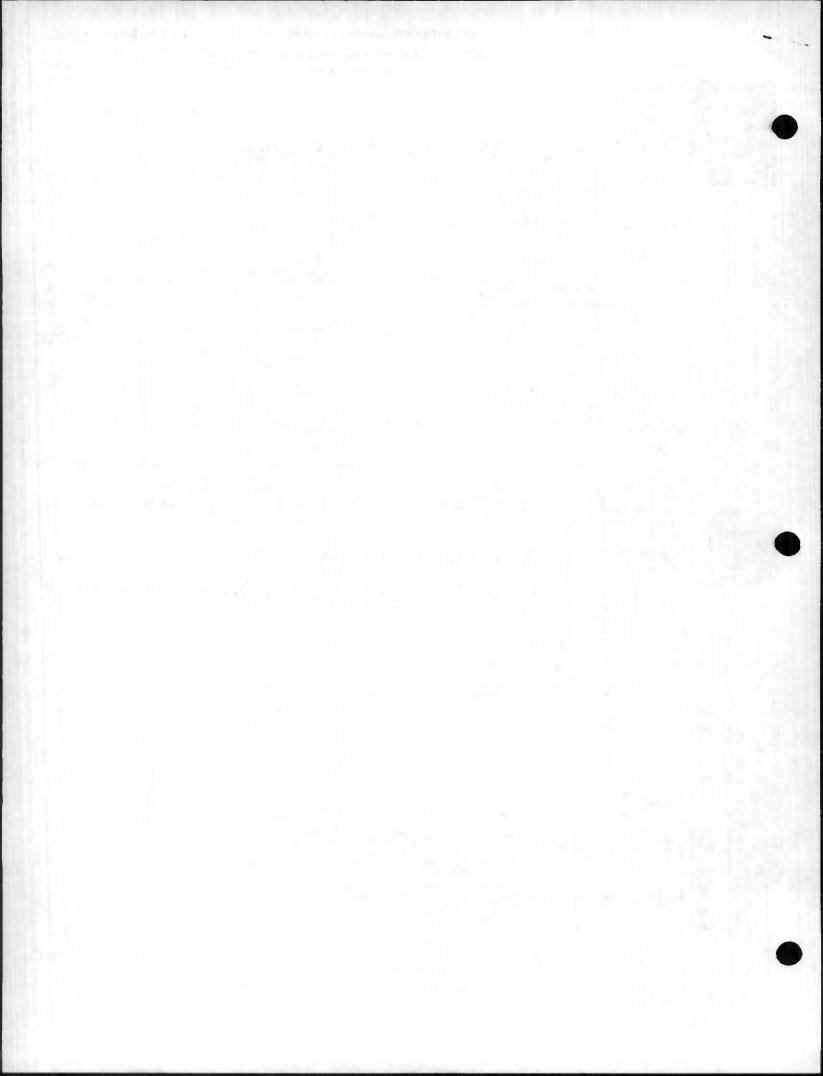
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/Med Exam	dical	4a Facility Name	(If not institution, give)			4b. City, Town	n, or Locatio	n of Death	4c. County	of Death		
LAUII		mera	1 Medic	-1 (tre			Balt	imasc	City				
Funera	al	5. Social Security	Number 6. S	ex 7. A		est birthday)	Under 1 Year	If Under 24	4 Hrs. 9 F	ate of Birth Month, Dey,	Vaari	9. Birthple	ece (Stete or	r Foreign
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efter des or items	by Funeral	165	rried 2 Married	12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	?		Decedent of les, specify Cub		in? (Specify Puerto Ricer	Yes or No- n, etc.)	Blac	a - America ck, White, e	etc.	
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S should be and Me source the summer to a		19a. Informant's N	Name/Relationship (Type, Print) Son	1	19b. Mailing A	ddrass (Straa	t and Number	or Rurel Ro	ute Number	City or Town,	Stete, Zip	Code)	
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of Heal itsm 2		20a. Method of Dis	•		0.6	ace of Disposition	on /Neme of				20c. Location -			
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Baltimore, parmit. Pages 1 a Department of Hea importent: if item any injury or othe	ouce.	21. Signature of F	uneral Service Licen	17 7		22. No.	ame and Addr	ess of Fecility	Jose	ph N	. Zann ore, M	ino	Jr.	224
		23a. Part1. Enter shock, or he	the diseese, or com art failure. List only	plications that cause one sause on each	d the death							-	Approximate Interval Bety Onset and D	a ween
Physician /Medica	_	Immediate Cause	(Final		Λ									
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68760, ifficate be executed g physician end as the bunal-transit	<u></u>	Cause (Disease o	r Injury	C										
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IS, P.O. BOX res that the death cer igned by the attendir be datached for use	Physician/M	A	ificant conditions of			itting In the unde	dying ceuse g	iven in Part I.		23b. Did to	bacco use co	ntribute to	the cause o	of death?
that the ed by		f	traction							1 🗆 Y	es 20 No	3 Prob	ably 4 🗆	Unknow
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Of VITAI RECORDS Physician: The law requires this cartificate hes been sign rail director, page 2 should be	Completed	6	ustmudes	had be	etin					24a. Wes a perform		ava	re autopsy fi ilable prior to npletion of ca	0
es b	hpie											of c	leath?	
The law ate hes by page 2 s	Con									1 □ Y	es 20 No	1 🗆	Yes 2□	No
r Vital Rec ysician: The law is cartificate hes b director, paga 2 s	Be (25. Was cese refe examiner?	erred to medical					26. Place	of Death (Cr	eck only or	10)			
Of Vita Physician: this cartific ral director,	70		No	Hospital:	ient 2 🗆 !	ER/Outpatient	3 DOA	her: 4 Nurs	sing Home	5 Reside	ence 6 🗆 Oth	er (Specify)	
o de de la constante de la con		27. Manner of Dea		28a. Data of Inj	ury av Year)	28b. Time of Injury	28c. Inju	iry at ork?	28d.	Describe ho	ow injury occur	red		
VISION Attending r deeth. sctor: After by the tune	atic	1 ☐ Matural 2 ☐ Accident	5 Pending investigation		,,	,,		Yas 2 N	lo					
DIVISION or Attending I atter deeth. Director: After d in by the tune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be detarmined	28a. Place of in	njury - At ho tc. (Specify	ma, farm, straet,	factory, office			Location (Si City or Town	treet and Numi n, Stata)	per or Rura	Route Num	ber,
Division of the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completaly filled in by the tuneral	edicai C	29a. Certifier (Check only one)		ysician: To the best niner: On the besis of and mannar s	of examinat									;)
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Y)	30. Name and add	ress of person who	Cuschen	death (Item	23a) (Type, Pri	301	St Pn.	191	BAI.	tines	212	20-	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2 Data of Death 3 Time of Death **Physician** lanuary 25 /Medical 4c. County of Death 4a. Facility Nama (If not institution, giva street and number, 4b. City, Town, or Location of Deeth Examiner Baltin If Under 24 Hrs. If Under 1 Year 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 6. Sex Birthplaca (Stata or Foreign Country) **Funeral** Days 1□ M 20XF 6130 62-Yrs. Director Usual Rasidance of Dacedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show Itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be not the dis 1 Yas 2 No Director Maryland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? items 23a Funeral 12. Wes Decedent Ever in U,S Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amaricen Indian, Black, Whita, atc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural". or hand linjury or other traument. 1 ☐ Yes 2 No If Yes, Giva Yaar or Datas: 1 Naver Married 2 Married Specify: While Baltimore, Maryland 21215-0020 1 Yas 20LNo Specify: by 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation
(Giva kind of work dona during most of working
lifa. DO NOT usa ratirad) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry McCornick & Com Elamantary/Secondery (0-12) College (1-4or 5+) 124RS 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Surname) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship, (Type, Print) 20b. Placa of Disposition (Name of camatary, cramatory or other placa) an 28 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signature of Funaral Sarvica Licansec 22. Nama end Address of Facility vans 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onset and Death **Physician** /Medical Immediate Ceusa (Final ERSBROYASELAR ACCIDENT disaasa or condition resulting in daath) Examiner Dua to (or es e consequança of): Examiner RETRIOD ADENO SIALIC physician end s the buriel-transit The law requires that the death certificate be asscuted Sequentially list conditions, if eny, laeding to immadiata cause. Entar Undarlying Causa (Diseasa or Injury that initiated evants rasulting in death) Last Due to (or es e consequence of) P.O. Box 68760, Physician/Medical Dua to (or as e consequence of): for use as 980 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be datached 3 □ Probably 4 □ Unknown 1 ☐ Yea 2 ☐ No Records, Be Completed by 24b. Wara autopsy findings aveileble prior to complation of ceusa of death? 24e. Wes en eutopsy performad? page 2 2 2 No 281 No cartificate 1 Yas Division of Vital or Attending Physician: director, 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) 1 Yas 2 No Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) Certification: To t⊠Inpatiant 2 ER/Outpatient 3 DOA this funerel 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Panding invastigation daath. To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completaly filled in by the fu 1 Yes 2 No 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 4 Homicida 29a. Certifier Medicai 12 Certifying Phyalcian: To tha best of my knowledge, death occurred et the tima, data and placa, and dua to tha causa(s) and mannar as statad. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or invastigetion, in my opinion, deeth occurred et the time, date and place, and dua to the causa(s) and manner stated. 29b. Signeture end titla of certifian 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 25, 1998 30. Nema and addrass Superson who complated cause of daath (Item 23a) (Type, Print) 21201 ALZJOH. R 22 SOUTH GREENE STREET 1275 BALTO. 110 31. Data filed (Month, Day, Year) JAN 28 1998 ge. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month EUGENE FLOWERS 7:201 4a. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death HOSPITAL Baltimore If Under 24 Hrs. 8. Da SECOURS 5 Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign Country) 12M 20 F Min 239-24-4730 Usuel Residence of Decedent 10h County 10d. Inside City Limits Baltimore NA 1 Ves 2 □ No Ma 10e. Street end Numbe 10f. Zip Code 10g. Citizen of What Country? Avenue 1600 5 12. Wes Decedent Ever in U.S. Armed Forces? //-/3 1 X/Yes 2 □ No If Yes, Give Yeer or Dates: /-//-11. Marital Status 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11-13-42 1 Never Married 2 Married 1□ Yes 2 No Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Bethlehem Elementery/Secondary (0-12) College (1-4or 5+) steer Laborer 2-th grade 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nathaniel Nora Flowers 19a/Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Reggie - Son Balto Flowers Moreland 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Burial 2 Cremetion 3 Removal from State 1/29/98 est Vet 4 Donation 5 □ Other (Specify) Jamson 21. Signature of Fuperal Service Licensee wabash Lerue Ba Ho, red 4300 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting In deeth) Last Pert II. Other significent conditiona contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed?

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: if item 27 is marked other than "ratural", or item any Injury or other traumatic event, the Mental Examined.

Baltimore, Maryland

Physician

/Medical

Examiner

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Director

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Physician/Medical Examiner Certification: à

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State Registrar

To the Hospital o within 24 hours at To the Funeral Di

Medical

1 Scrifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and place, end due to the cause(s) end manner stated. 29a. Certifier 29b. Signature end title of certifier

5 Pending investigation

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Dey, Yeer)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

2 No

2 No

30. Name and eddress of person who completed cause of death (Item 23) (Type, Print)

BONSECOURS

26. Piece of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

31. Dete filed (Month, Dey, Year) JAN 28 1998

25. Wes case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

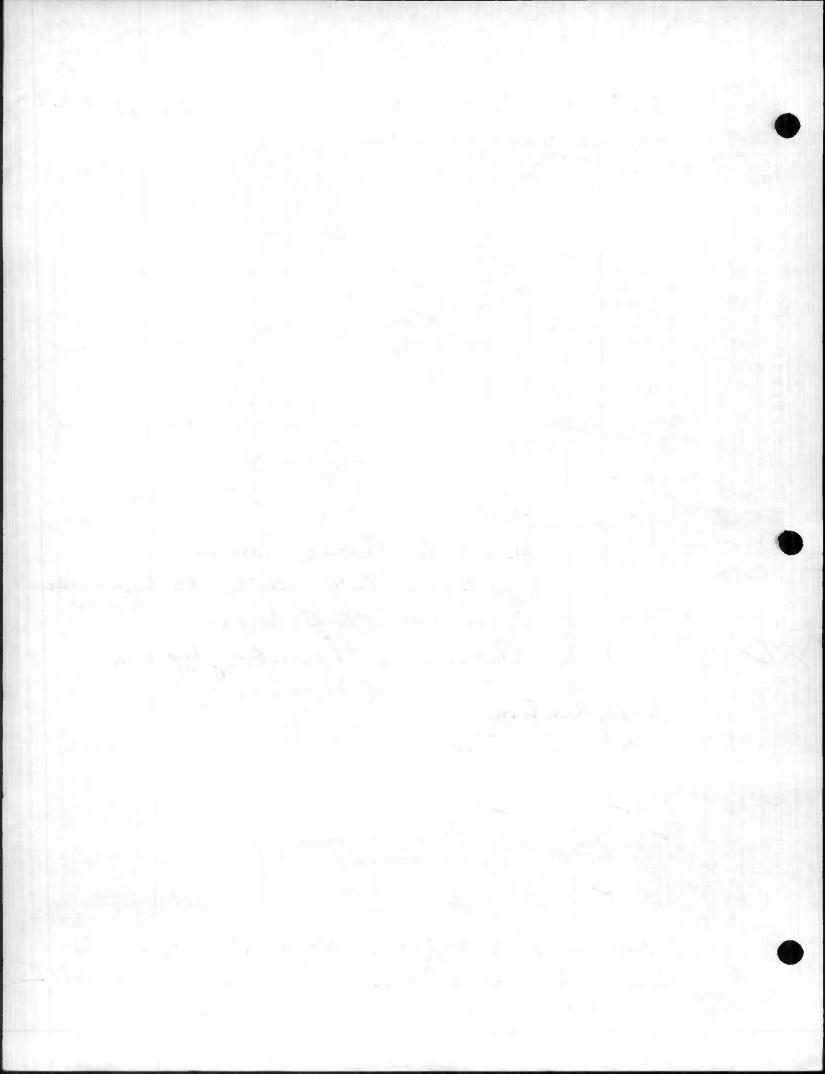
1 Naturel

2 Accident

3 Suicide

4 Homicide

32. Begistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month QUEE 2:10pm 1998 an /Medical 4a. Facility Nama (Most institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Delue 1+imore 5. Social Security Number If Undar 1 Yaar If Under 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Months Days 218-28-2914 10 M 20% Yrs Director 01 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits Baltimore Md NA 1 TLYES 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6413 2810E aurel 21207 Funeral Was Decedent of Hispenic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Peges 1 end 2 should be filed within 72 hours effer c Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Houldal Examina. 1 Yes 2 No If Yes, Give Year or Datas: 1 Never Married 2 Married 1□ Yes 2□No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Spacify only highest grade complated) Elementery/Secondary (0-12) College (1-4or 5+) 12+n I E LE RECRUITER 17. Father's Nama (First, Middla, Last) 18-Mother's Name (First, Middle, Maiden Sumame) Chasen GORNAM Janes GATRICE 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 64131 2120r harles to 20b. Place of Disposition (Name of cametery, cremetory or other place 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1.30.98 ☐ Donetion 5 ☐ Other (Specify) Kidge Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility INC. March F. H. West 23a. Part. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert beliure. List only one cause on each line. Ba HO MA 21215 Approximete Intervel Between Onset and Death Immediata Causa (Final OLON disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy performed? 1 Yas 200 No 25. Was case referred to medical examiner? Be 28. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Dolatural 5 Pending investigation 1 Tes 2 No 2 Accident

687 P.O. Box Records, Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifice completely filled in by the funeral director; s

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Baltimore, Maryland 21215-0020

28a-f show must be notified at

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items 23a

Physician /Medical

Examiner

signed by t

page 2

3 Suicide

29a. Certifier

4 Homicide

29b. Signetura and title of certifier

31. Date filed (Month, Day,

28 1998

6 Could not be

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

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completed cause of death (Item 23a) (Type, Print)

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retifying Phyeiclen: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the ceuse(s) end menner es steted.

Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and manner stated.

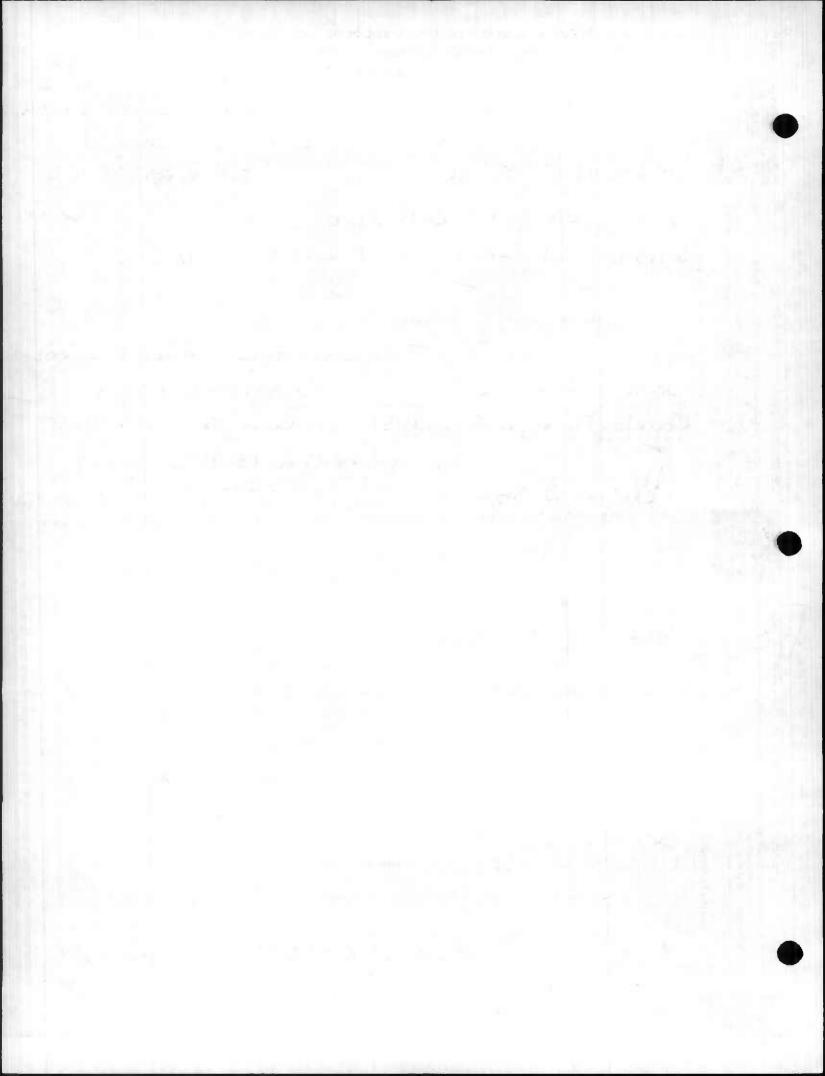
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29d. Date signed (Month, Day, Year)

certificate

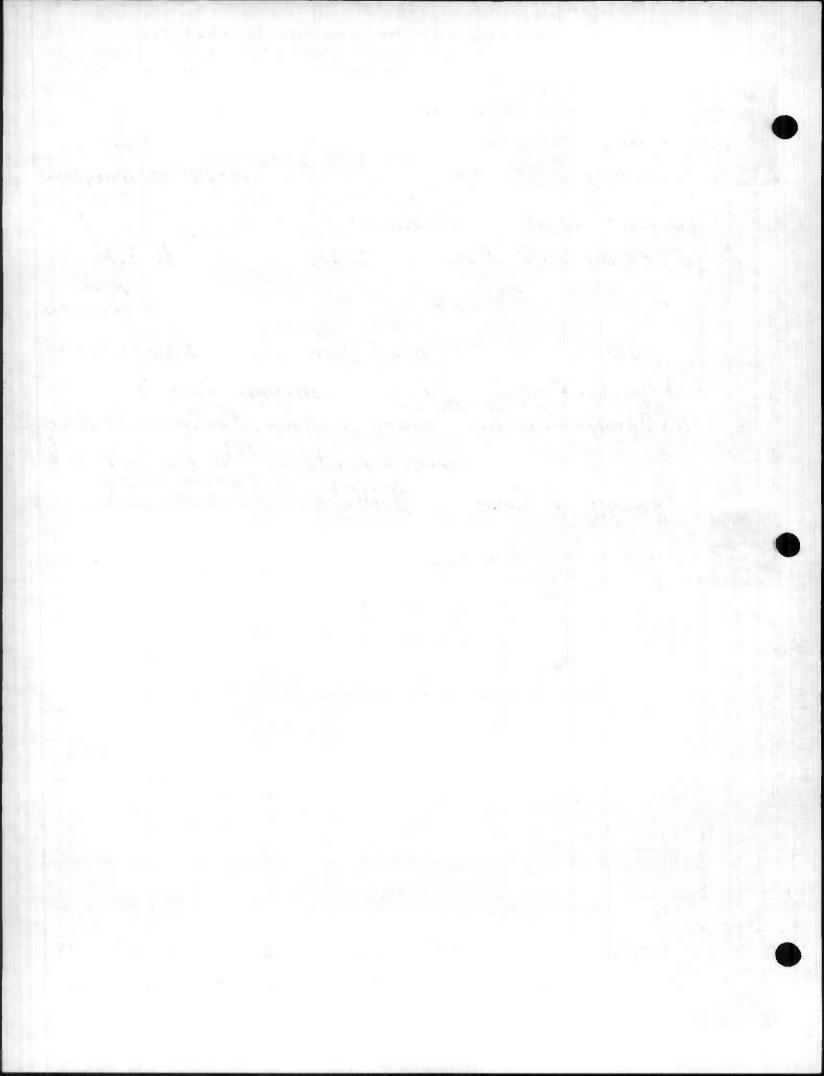
State Registrar

Medical



State of Maryland / Department of Health and Mental Hygiene 8 0 2 0 2 6

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		24. Holnes HE				Baltim		10/	H.
Funera		5. Social Security Number 6. S	Sex 7. Age (In yrs	Monti	hs Days		8. Date of Bir (Month, Da	th ly, Year) 9.1	Birthplace (State or Foreign Country)
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2 -		Usual Residence of Decedent							/
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ore, Ma s 1 and 2 a Health ar Herm 27 is		20a. Method of Disposition	20b.	Place of Disposition (Name of	rinfoes	Date	20c. Location - City	or Town, State
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Balt Depart Import Impo		21. Signature of Funeral Service Licer	nsee	22. Name	and Addre	ess of acility	TUNE,	Al Hon	4
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AN Ho	edical	(Check only 2 Medical Exar	niner: On the basis of examin and manner stated.	ation and/or Investigat	tion, in my o	opinion, death occur	rred at the time,	date and place, and	due to the cause(s)
NAME JOHN FORTH REPORT OF TO the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	M	29b. Signature and title of certifier	mainter diatos.		29c. Licens	se number		29d. Date signed (M	onth Day Year)
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, (Haytham Bish	ona St Agn	es Hospita	rl c	700 Cato	n Ave	Baltima	re MD 21229
St	ate	31. Date filed (Month, Day, Year)	32. Registrags Sign	ature					- LILL GIVE J.
Regist		JAN 28	1998 \ Julia.	Tail &					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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_c Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days			th Voor	9. Birthplece (State or Foreign
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how	1.	10a. State 10b. County	10c. Cit	y, Town or Loca	ation		·		10d. Inside City Limits
Be-f-s	cto	MARYLAND BALTIMORE	BA	LTIMORE	E				1 ☐ Yes 2 ☐ No
or 2	Director	10e. Street end Number			10f. Zip Code			10g. Citizen of W	hat Country?
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and 2 aaith a n 27 is		GEORGIA DILELLA, DAUG	HTER	1107 F	REGINA D	DRIVE, BA	LTIMORE,	MARYLAN	ND 21227
0 0		20a. Method of Disposition		Place of Disposit	tion (Name of	ice)	Dete	20c. Location - (City or Town, State
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hyslcian									Onset and Deeth
/Medical xaminer		Immediate Ceuse (Final disease or condition	CEREBR	Ac	JITR	om Bo	215		4 days
Xui i i i i i	-	resulting in death) e	Due to (o	r as e conseque	ence of):				
nsit	Examiner	b							
al-tra	xar	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying	Due to (o	r es a conseque	ence of):				
ttanding physiclan and for usa as tha bunal-transit		thet initiated events	Duo to /or	r es a conseque	man offi				
g phy as th	Po	resulting in death) Last	Dde (0 (0)	es a conseque	rice or):				
andin	lan/Medical	d							
		Part II. Other significent conditions contributir	g to death but not resu	ulting in the und	erlying cause giv	ven in Pert I.	23b. Did 1	obacco use con	tribute to the cause of death?
t by that	Physic	ALZHEIMET	7	m	1				3 □ Probably 4 □ Unknown
gned ba da	by	1, 40 (1110)	· be	MAN	114				
been signed by tha should ba datached	Completed	HUPO THURS	1 DISM					en eutopsy med?	24b. Were eutopsy findings eveilable prior to
ies been signed b 2 should ba data	ple	1) - 1/0 / . / 1/-0	7,37,17-1				, i		completion of cause of deeth?
page	Con						101	es all No	1 ☐ Yes 2 ☑ No
s cartificata hes diractor, page 2	Be	25. Wes cese referred to medical examiner?					ath (Check only o	ne)	
this aldi	7	1 Yes 2 No Hospite	1 □ Inpatient 2 □ I	ER/Outpetient	3□ DOA Oth	4 Nursing F		ence 6 Othe	
Aftar funar	lo.	Netural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Describe h	ow Injury occurre	d
daatt	Certification:	2 Accident Investigation 3 Suicide 6 Could not be	Dings of Injury. At he	mo form street		Yes 2□No	20f Longtion /6	Neont and Mumba	and Dural Courts Alumbus
Direct Direct In	ertii	4 ☐ Homicide determined 286.	Plece of Injury - At ho building, etc. (Specify	/)	t, ractory, office		City or Tou	n, State)	r or Rural Route Number,
within 24 hours after daath. To the Funeral Director: After thi completely filled in by the funaral		29a. Certifier Certifying Physician:	To the best of my know	viedae deeth o	ccurred et the tir	me dete end niece	end due to the	euse(s) and men	ner ee eteted
• Fur	edicai	(Check only 2 Medical Examiner: On	the basis of examinet	ion end/or inves	stigation, in my o	ppinion, deeth occu	rred et the time,	late end place, er	nd due to the ceuse(s)
within 24 hours after death. To the Funeral Director: After completely filled in by the funar	M	29b. Signature and title of certifier			29c. Licens	se number		29d. Dete signed	(Month, Day, Year)
		Jasuem Loo	a Carrie	m)	129	8595		1/201	98
11	1	30 he he end eddress of person/who complete	d cause of deeth (Item		int)		Λ	1	, -
9		Jaseren Lalelie	an, 722	7)	k He	ICAHT /	TYE 1	SALM	Mn 21208
Sta	te	31 Dete filed (Month, Dey, Year)	32. Registrar's Signet	ture	.,			J., ., ., .	
		1811 00 4000	A	-					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth ANN 1998 JANUARY 24 4b. City, Town, or Location of Deeth 4c. County of Death BALTIMORE If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 M 2 F Months Deys Hours 54 Yrs. AUG. 20. 1943 10h County 10c. City. Town or Location Anne Arundel Pasadena 10f. Zip Coda 10g. Citizen of What Country?

1. Decedent's Neme (First, Middle, Last) 3 Time of Deeth **Physician** 10:30 pm /Medical 4a. Fecility Neme (If not institution, give street and number) **Examiner** THE JOHNS HOPKINS HOSPITAL 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Director 212-44-8455 Maryland Usuel Rasidenca of Deceden death with the Maryland 10e State 10d. Inside City Limits 28a-f show ims 23e or 28a-f short must be notified at Director 1 ☐ Yes 2 ☑ No Md. 10e. Street and Number 30 Milburn Circle Funeral 21122 USA or items 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11. Marital Status The Medical Examiner filed within 72 hours after 1 ☐ Never Married 2 ☐ Merried 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: white 3 ☐ Widowed 4 ☐ Divorced natural Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retirad) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry I Hygiena. Elamantery/Secondary (0-12) Collega (1-4or 5+) 12 Day Care Provider Self-employed traumetic event, Baltimore. Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 is merked oth lury or other traumatic even Be Wilfred Zeuch ပ Elizabeth Weaver 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Gayhardt - husband 30 Milburn Circle, Pasadena, Md. 21122 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 1/28/98 permit. Page Depertment of important: If any Injury or Meadowridge Mem. Park Elkridge, Md. 21. Signeture of Funaral Service Licensee 22. Name end Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP 23a. Pent Enfer the disease, or complications their caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceusa on each line. Interval Between Onset and Deeth **Physiclan** /Medical Immediate Cause (Finel disease or condition rasulting in death) Examiner ra The law requires that the death certificete be axecuted the burial-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disaase or Injury that initiated events resulting In deeth) Last attending physician Physician/Medical Due to (or es e consequence of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of daeth? Completed 24e. Wes an autopsy performed? this certificate has been spital or Attending Physicien: Theoris after death.
neral Director: After this certificati
y filled in by the funeral director, ps Be 25. Was case refarred to medical 26. Place of Deeth (Check only one) examiner' 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 1 Sepatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Daath Date of fnjury (Month, Day 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Spacify) 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral DI complataly filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceusa(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the causa(s) and mennar stated. 29e. Certifier Medical 29c. License number 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) 30. Neme and eddress of person who completed ceusa of daeth (Item 23e) (Type, Print) 600 N. Wolfe ST

P.O. Box 68760, Division of Vital Records,

8

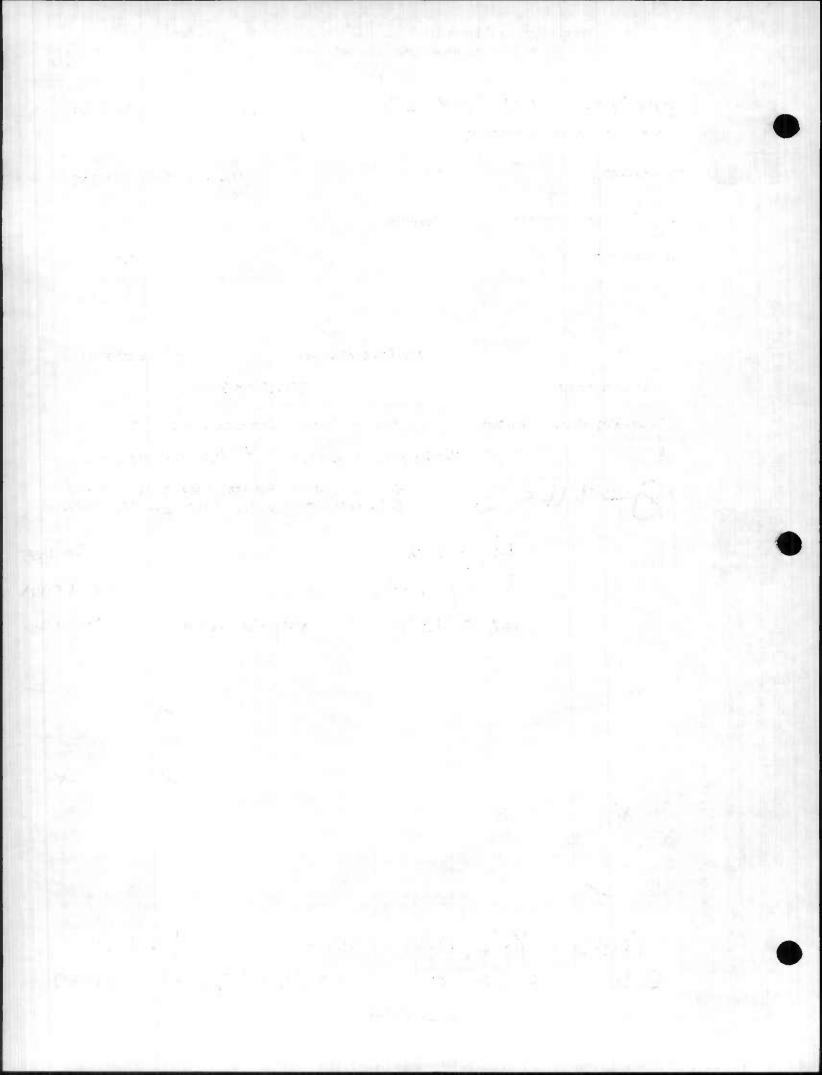
State Registrar

JAN 28 1998



DHMH 16 Bey 6/95

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 5:34 Am Cramble 4b. City, Town, or Location of Death , 1998 26 4a. Fecility Name (If not institution, give street end number) 4c. County of Deeth Baltimore Sihai Hospital Baltimore If Under 24 Hrs. 8. Date of Birth
Hours Min. SEPT, 27, 1927 South CAROLINA 6. Sex 1⊠M 2□F If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 247-40-8563A 70 Yrs. Usuel Residance of Dacedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits

BALTIHORE CITY

21209

Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 No Specify:

16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

CARPENTER

1X Yes 2 □ No

10a. Citizen of Whet Country?

USA.

16b. Kind of Business/Industry

29d. Date signed (Month, Dey, Year) January 26, 1998

14. Race - American Indian, Black, White, etc.

Specify: BLACK

SELF-EMPLOYED

Funeral Director

Physiclan

/Medical

Examiner

Directo

Funeral

b

Completed

MARYLAND 10e. Street end Number

6608

NIA

ROAD

1 ☐ Yes 2 No If Yas, Give Yeer or Dates:

Collega (1-4or 5+)

12. Wes Decedent Ever in U,S. Armed Forces?

SANZO

15. Decedent's Education (Specify only highest grade completed)

1 Nevar Merried 2 Married

3 Widowed 4 □ Divorced

Elamantary/Secondary (0-12)

4++GRADE

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene important: if lean 27 is marked other than "n any injury or other traumatic event

> **Physician** /Medical Examiner

Box 68760,

sion of Vital Records, P.O.

physician end the burief-transit signed by t cartificate Attending Physician: death. After pital or Attached

Examiner Physician/Medical by Completed Be

17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Sumame) GAMBLE SYLVESTER 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) 6608 SAN ZO ROAD, BALTIHORE, MD, 2/209 ca of Disposition (Name of Data 20c. Location - City or Town, Steta EARLY (SISTER) EARLY YOUNG
20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 1 Burial 2 Cremetion 3 Removal from Stete MT ZION CEMETERY

22. Name end Address of Facility 01-31-98 LANSDOWNE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 23e. Pert1. Enter the disease, or complications that caused the grant. Do not enter the mode of dying, such es cardiac or respiretory errest,

Approximeta Immediete Ceusa (Finel diseesa or condition rasulting in daeth) 2 days Sepsis Due to (or es e consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Entar Underlying Cause (Diseesa or Injury thet initieled events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Status post cerebral vascular accident 24b. Were eutopsy findings evellable prior to complation of cause of daeth? 24e. Wes en eutopsy performed? status post myocardial infarction status post aortic aneurysm report 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical axaminer?

1 Yes 2 No 26. Pleca of Daath (Check only one) Hospitel: 1

Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28e. Data of Injury (Month, Dey Year) 27. Mannar of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicida 12 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to tha causa(s) and mannar es steted.

2 Medical Examinar: On the basis of axamination end/or investigetion, in my opinion, deeth occurred et tha time, data and place, end due to the cause(s) and menner stated. 29e. Certifier (Check only one)

29c. License number

Sinai Hospital

32. Registrer's Signature

AS 2402321 mw 9515

Baltimore, Maryland

State Registrar

Medical

29b. Signeture end title of certifier

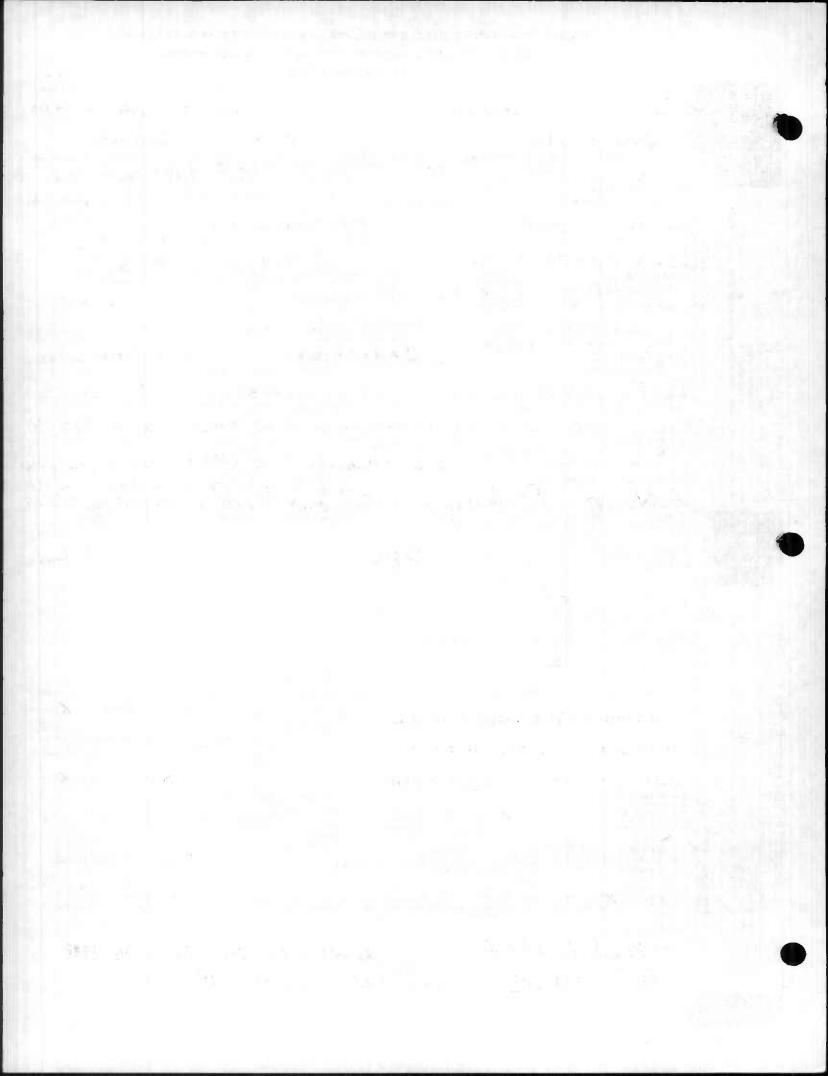
Mark Wahl.

31. Deta filed (Month, Day, Year) JAN 28 1998

30. Nema and eddress of person who complated cause of deeth (Item 23e) (Type, Print)

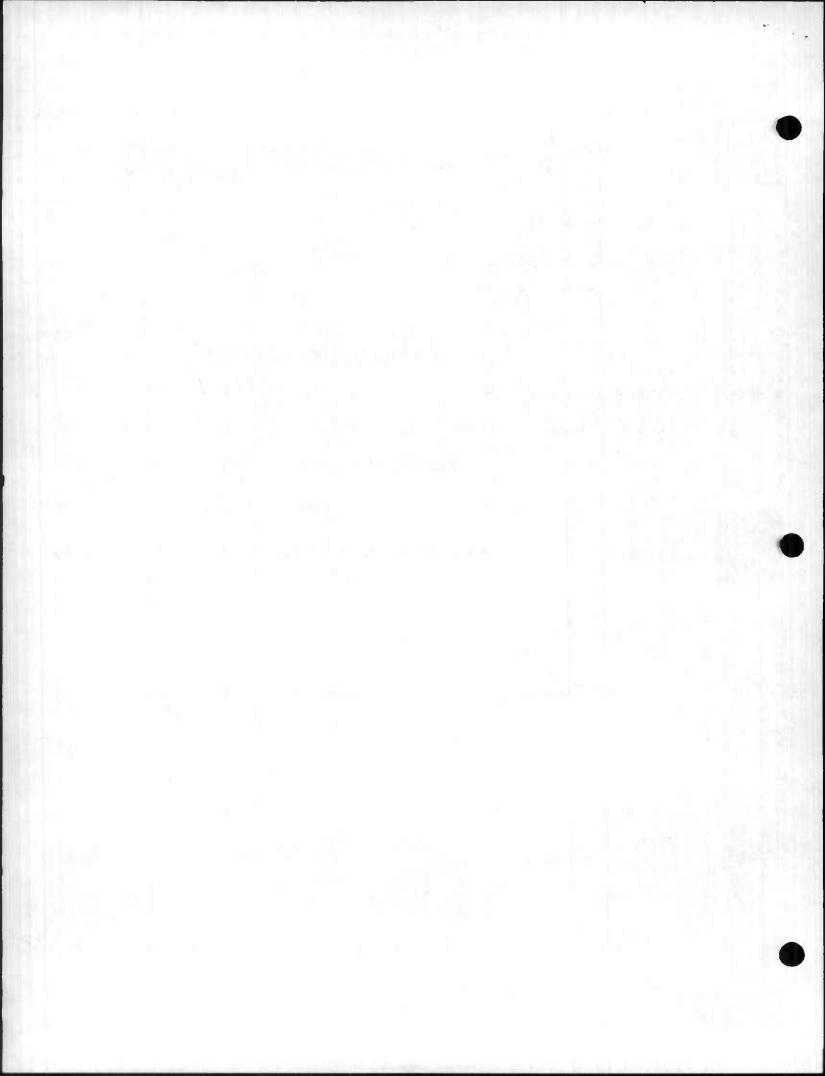
MD

To the within To the comple



State of Maryland / Department of Health and Mental Hygiene 98 02030

				Certifica	ate of Death	R	eg. No.	020	JU	
Physicia /Medica		1. Decedent's Neme (First, Middle, Las	"Ghont JR			2. Dete of Dee Month		3. Ti	me of Deeth	
Examine		4e. Fecility Name (If not institution, give	street end number)		Chas	Location of Deeth	4c. County	of Deeth HMOR	0	
Funeral Director		5. Social Security Number 6. Security Number 1] Usuel Residence of Decedent	7. Age (In yrs.	lest birthday) If Uni Month	der 1 Year If Under 24 Ar he Days Hours Mir		1920	9. Birthplace (S Country)	and	
-f show	ior	10a. State 10b. County	10c. Ci	ty, Town or Location					ide City Lir	
23a or 28a-f should be notified at	I Director	10e. Street end Number 7892 Sullingst	Propodis a 101	10f.	Zip Code RUQQ17	1	0g. Citizen of W	/het Country?		
of tems	by Funeral	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 XYes 2 No If Yes, Give Year or Detes:		cedent of Hispenic Origin? (pecify Cuban, Mexicen, Pue	Specify Yes or No- rto Rican, etc.)	14. Race Bleck	a - American Indi k, White, etc.	en,	
jena. r than "naturel". The Medical Ex	Completed	15. Decedent's Edi (Specify only highest grad		16e. Decedent's U (Give kind of life. DO NOT	suel Occupation work done during most of wire use retired)	orking VINTONT	KPMG		uedm	
o dal	To Be Co	17. Father's Neme (First, Middle, Lest) WILLIAM G. GI	unt Sr.	CRIMO	18. Mother's Na	ame (First, Middle, I	Maiden Sumem	o)		
f Haalth and Mer tem 27 ie marks other treumetic		19e. Informent's Neme/Relationship (7)	t wife	19b. Mailing Addr	ess (Street end Number or F PLO Rd. Ball Name of	timore, 1	Jarylai	nd 212	20	
ant: if I		20e. Method of Disposition 1 Buriel 2 ACremation 3 4 Donetion 5 Other (Specify, 21. Signeture of Funeral Service Licens	Removel from State	cometery, crometory c	Cemelery	Jan. 27	Baltimu	OED, Ma	eylan	
Departr Importa any inj		desta S.	Wells	8800	end Address of Fecility & Harterd Rd	Baltim	sel, Ma	eyland s	2123	
hysician /Medical		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only o	A					interv	ximete el Between end Deeth	
Examiner	ě	diseese or condition resulting in death)	е	or es e consequence	OCARP/AL	PATK	S/10 N		TAP	
sician and burial-transit	Examiner	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events	b. Due to (c	or es e consequence d	of):					
ng physicia	Medical	Medical	resulting in deeth) Lest	CDue to (c	or es e consequence d	of):				
ed for us	Physiclan/	Pert II. Other eignificent conditions co		sulting in the underlyin	g ceuse given in Pert i.	23b. Dld to	bacco uee con	tribute to the ca	usa of de	
igned by the a						1 🗆 Y	95 3 No	3 Probably	4 ☐ Unk	
as been sign	Completed by					24a. Wes e perfon	n eutopsy ned?	24b. Were eute eveileble completio of deeth?	opsy findin prior to n of ceuse	
	Be Con	25. Was cese referred to medical			26 Please of Di	1 ☐ Yo		1 ☐ Yes	2 No	
00	2	exeminer?		ER/Outpetient 3	DOA Other: 4 Nursing	Home 5 ₹,Reside		ar (Specify)		
E all	cation:	27. Manner of Deeth 1 Manuary 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury et Work? 1 Yes 2 No	28d. Describe h				
vithin 24 hours after death. Within 24 hours after death. To the Funeral Director: A completely filled in by the it	edical Certification:	4 Homicide determined	28e. Piece of Injury - At h building, etc. (Specified) eiclen: To the best of my kno	(y)		28f. Location (Si City or Town	n, State)		rvum <i>ber</i> ,	
in 24 h		(Check only 2 Medicei Exami	ner: On the basis of examina end menner steted.	ition end/or Investigati	ion, in my opinion, deeth occ	curred et the time, d	ete end plece, e	nner es stated. and due to the ca	use(s)	
Total	-	29b. Signature end title of certifier And WO	workend	- mo	29c. License number D 0 8 0 9		9d. Dale signed	RY Z	2,19	
BY		30. Name end eddress of person who co	empleted ceuse of deeth (item	n 23e) (Type, Print)	N. Main St					
State	C .	31. Date filed (Month, Dey, Year)	32 Registrar's Signa	ature Randelle	D. HUWIL D		114, 170			



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth HEADY Year Month Tanuary 1998 21

Physician /Medical Examiner

Funeral Director

deeth with the Meryland r than "natural", or items 23a or 28a-f ehov the Wedical Examiner must be notified at filed within 72 hours after Hygiena. it of Health and Mentel Hygis if Item 27 is marked other or other traumatic event, Peges 1 and 2 should be nent of Health and Mentel

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Examine

Physician/Medical

þ

Completed

Be

Certification: To

edical

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in deeth) Last

1 Yas 2 No

27. Mannar of Death

1 Matural

2 Accidant

3 Suicida

29a. Certifiar

4 Homicide

(Check only one)

permit. Pege Department of Important: If any Injury or once.

ng physician end es the burial-trensit USB signed by the a certificeta has b lirector, pege 2 s nours after death.

neral Director: After this filled in by the funerel di After this

The law requires that the death certificeta be axecuted

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

To the Hosp within 24 hor To the Fune completely fi 10+1

24 hours

Registrar

3. Tima of Death 1. Decedant's Name (First, Middla, Last) WARDEN 4:15 RM 4b. City, Town, or Location of Death 4a Fecility Nama (If not institution, giva straat end number) 4c. County of Death BALTIMORE CITY HARBOR HOSPITAL CENTER N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplaca (State or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days 406-32-5105 71 Yrs 1926 NOV. 1. Kentucky Usual Rasidanca of Decedant 10c. City, Town or Location 10d. Insida City Limits 10a, Stata 1 TyYas 2 □ No Directo Md. N/A Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4821 Pennington Avenue 21226 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indien Black, Whita, atc. 11 Marital Status 1 Types 2 No
If Yes, Giva
Yaar or Datas: 1945-47 1 Navar Married 2 Merried 1 ☐ Yas 2 ☐ No Specify: white þ 3 XWidowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Mechanic Modern Trash Removal 11 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Father's Nama (First, Middle, Last) Warden Heady Louvine Stone 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Mary Frazier - daughter 2615 Daisy Avenue, Lansdowne, Md. 20b. Placa of Disposition (Nama of camatary, cramatory or other plece) 20c. Location - City or Town, State 20a. Mathod of Disposition Dete 1/27/98 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Spacify) Baltimore Washington Crem! Laurel. Md. 21. Signatura of Funeral Service Licensea 22. Nama and Addrass of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP For 7250 Washington Blvd., Elkridge, Md. 23a. Part 1. Enjer the disease, or complications that caused the deaths shock, or heart failure. List only one ceuse on each line. Interval Between Onsat and Death fmmediate Causa (Final disaasa or condition rasulting in daeth)

& METASTATIC COLON CANCER

Dua to (or as e consequence of):

Dua to (or as e consequance of): Due to (or es a consequança of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

PULMONARY EMBOLISM

5 Panding Invastigation

6 Could not be

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

3 MONTHS

24b. Were autopsy findings evailable prior to complation of cause of death? 24a. Was an autopsy performed?

1 Yas 2 No 1 Yas 2 No

25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Inpetiant 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Dascribe how injury occurred

28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury et Work? 1 Yas 2 No

28f. Location (Street and Number or Rural Routa Numbar, City or Town, Stete) 28a. Pleca of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. Licansa number

29b. Signetura and titla of cartifia HOUSE STAFF

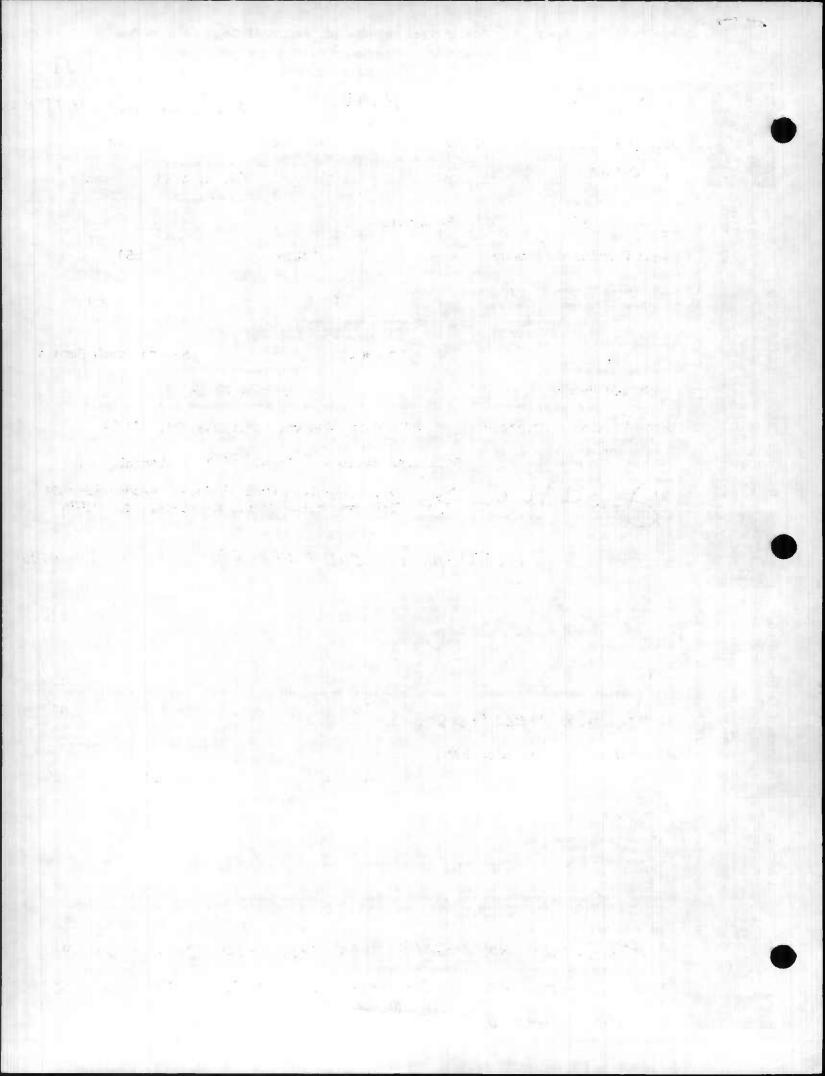
AS 2441614-60

29d. Data signed (Month, Dey, Year) January

30. Nama end addrass of person who complated causa of daath (Itam 23a) (Type, Print)

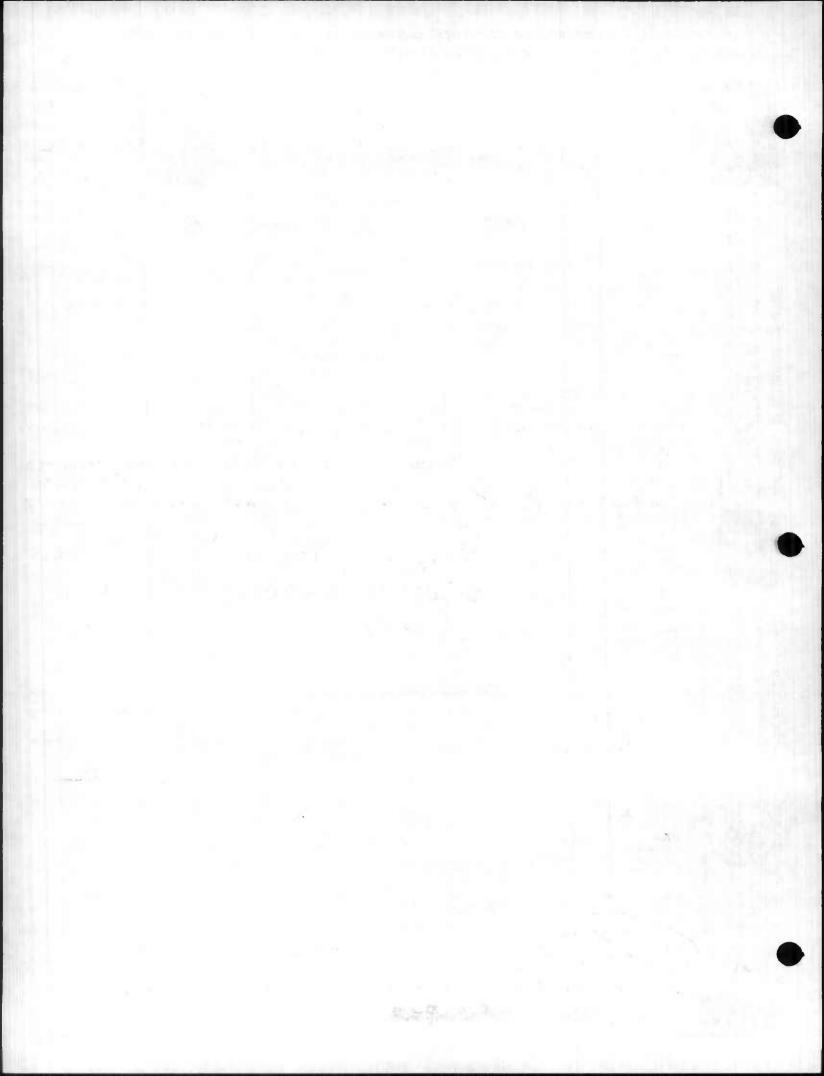
ATHIR MEROGI, HARBOR HOSPITAL CENTER BOOL SOUTH HANDUER STREET J. M.D.

32. Radistrar's Signatura Jandalle 31. Date filad (Month, Day, Year) 28 1998



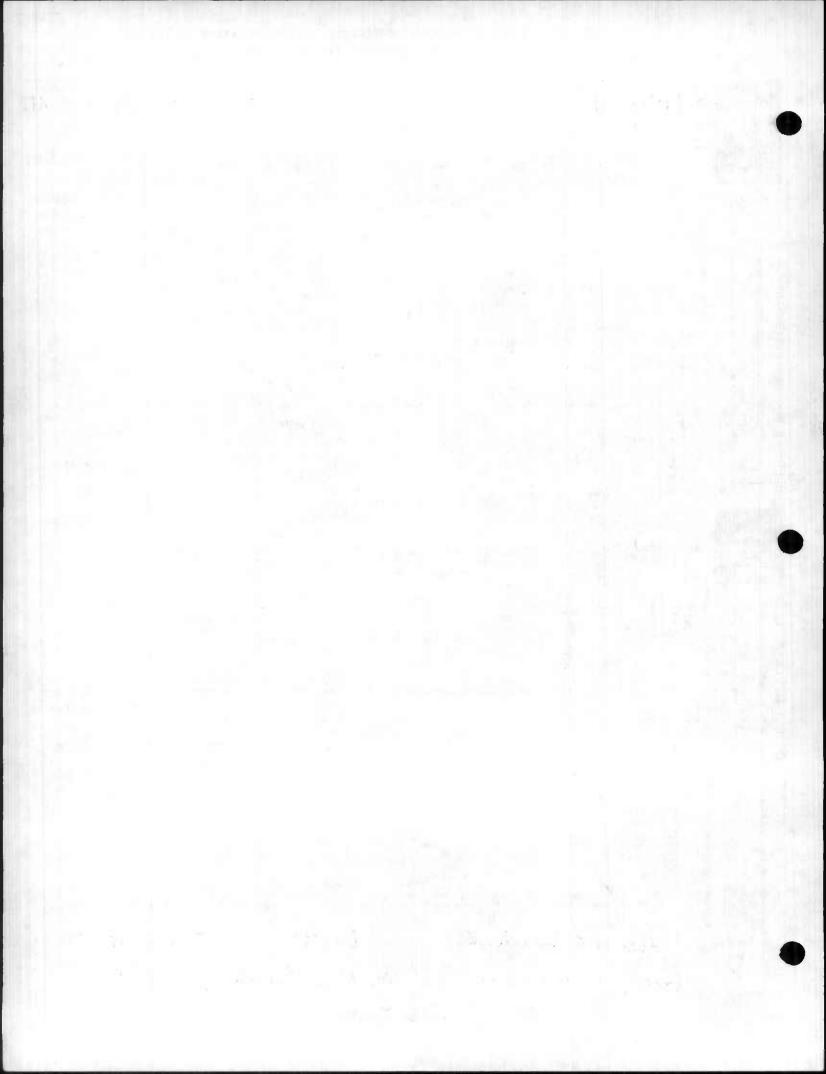
State of Maryland / Department of Health and Mental Hygiene 3 2 0 3 2

			Certificate of De	eath	Reg. No.	12002
	Physic	ian	Decedent's Nama (First, Middla, Last)	2. Deta of D Month		3. Time of Death
	/Medi	cal	ARTHUR W. HYDE	JANUA		18 3:27AM
	Exami	ner	C = 1 = = - F	City, Town, or Location of Dea		
-	Funeral		5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year III U	Under 24 Hrs. 8 Data of B	N BA	Birtholece (State or Foreign
L	Funeral Director			Undar 24 Hrs. 8. Data of B Hours Min. (Month, I	7,1913 V	Birthplace (Stata or Foreign Country)
	yland		10a. Stata 10b. County 10c. City, Town or Location		,	10d. Inside City Limits
	the Mar	ector	MARYLAND BALTIMORE RAND, 10e. Street and Number 10f. Zip Code	ALLSTOW		1,⊠Yes 2□No
	th with 23a or	Funeral Director	7 0	21244	10g. Citizan of What	
	terns terns	uner	11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Dacedant of Hispen If Yas, specify Cuben, M.	nic Origin? (Spacify Yes or Naxicen, Puarto Rican, etc.)		Amarican Indian, Vhita, atc.
5-0020	swithin 72 hours effer deeth with the Maryland ilene. Than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at	by	1 Never Marriad 2 Married 1 X Yas 2 No C-10-44	pecify:	Specify:	BLACK
5-(netu netu	Completed	15. Dacedant's Education (Specify only highest grade completed) (Grade kind of work done during life. Do NOT use retired)	ng most of working	16b. Kind of Busine	ass/Industry
121	within ene. than "	dE.	College (1-4075+)	4	0000	
d 21	H T T		UNKNOWN REPAIR MAN 17. Father's Nama (First, Middle, Last) 18.	Nother's Nema (First, Middl	(a. Meiden Surneme)	· y
land		To Be	11	UNKNOWN	a, molecul damente,	
Maryl	of DE E	-	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and N		ber, City or Town, Ste	ta, Zip Coda)
2	C TO N F		LILLIE C. HUDE (WIFE) 7005 RUDISI	- #		STOUN, MAZIZ44
ore	of Heal of Heal f Itam 2 r other		20a. Method of Disposition (Name of cematary, cramatory or other place)	Data	20c. Location - City	or Town, Stata
altimor	Peg nent int: If		1 ABurlel 2 □ Cramation 3 □ Ramoval from State 4 □ Donation 5 □ Othar (Specify) ARBUTUS (EMF-TE	ERV 01-29-9	& ARBUTUS	S. MARVLANA
Balt	permit. Peg Department Important: f any injury o		4 Donation 5 Other (Specify) 21. Signature of Funeral Servica Licensee 22. Nama and Address of SOSEPH H	Facility ROWN =	R, FUNE	EAL HOME
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0.7	Physician		23a. Part1. Entar tha disaasa, or complications that caused the leath. Do not anter the moda of dying, su shock, or heart failure. List only one cause on each line	_ 1		Intervel Batwean Onsat and Death
	/Medical		Immediata Causa (Final	74 1 14 10		1/2/1
П	Examiner		diseesa or condition resulting in death) Dua to (or as a consequence of);	· CHURE		1000
-	P =	her	- EMUCY Phys	SOING		Threak
	icete be executed physician end s the burial-trensit	Examiner	Sequentially list conditions, if eny, laading to immadiata ceusa. Enter Underlying			
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P.0	the de py the day	Physician/	Part II. Other significant conditions confributing to death but not rasulting in the underlying cause given in			uta to the cauea of death? Probably 4 Unknown
	requires that the seen signed by the should be detache	by P	- ATP) ras 2 140 3 ja	griously 4 onknown
Division of Vital Records,	v require been sig should t		Donne	24a. Wa	s an autopsy 24 formed?	b. Were eutopsy findings available prior to
9	2 S S	Completed	JU IYUNNA			complation of cause of death?
<u> </u>	The ate h	S		1 🗆	Yes 2 No	1 □ Vas 2□ No
/ita	Physician: The second disorder, par	Be	axammer	. Placa of Death (Check only	ona)	
6	hysicie Mis cen direg	2		Nursing Home 5 ☐ Ras		Specify)
g	Bull and	lo	27. Mannar of Deeth 1 Natural 5 □ Panding 28a. Dete of Injury (Month, Day Year) 28b. Tima of Injury at Work?		how injury occurred	
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S.	545	Certification:	4 Homicida determined determined determined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)		own, Stata)	nurai nouta Number,
	To the Hospital or within 24 hours effu to the Funeral Dir completely filled in		29a. Cartifier (Cherk only) (Cherk only)	ete end place, and due to the	e ceusa(s) and manne	r es steted.
	n 24 n 24 ne Fu	edical	(Check only one) 2 Medicaf Examiner: On the basis of axamination and/or invastigation, in my opinion and manner stated.	n, daath occurred et tha tima	, dete and plece, and	dua to the ceuse(s)
	To the Hospital within 24 hours e To the Funeral C completely filled	X	29b Signature and tale of certifier 29c. Licanse num		29d. Data signed (Mi	
		(D1711	18	1/26/9	P
	140,		30 Name and address of person who complated cause of daeth (Itam 23a) (Type, Print)	-1 0	,	
	1		30 Name and address of person who completed cause of daeth (Itam 23a) (Type, Print) Taul Schwartz M.D. 400 Old Control 31. Data filad (Month, Day, Year) 22. Registrar's Signature	ite 203 Balt,	Md 21208	
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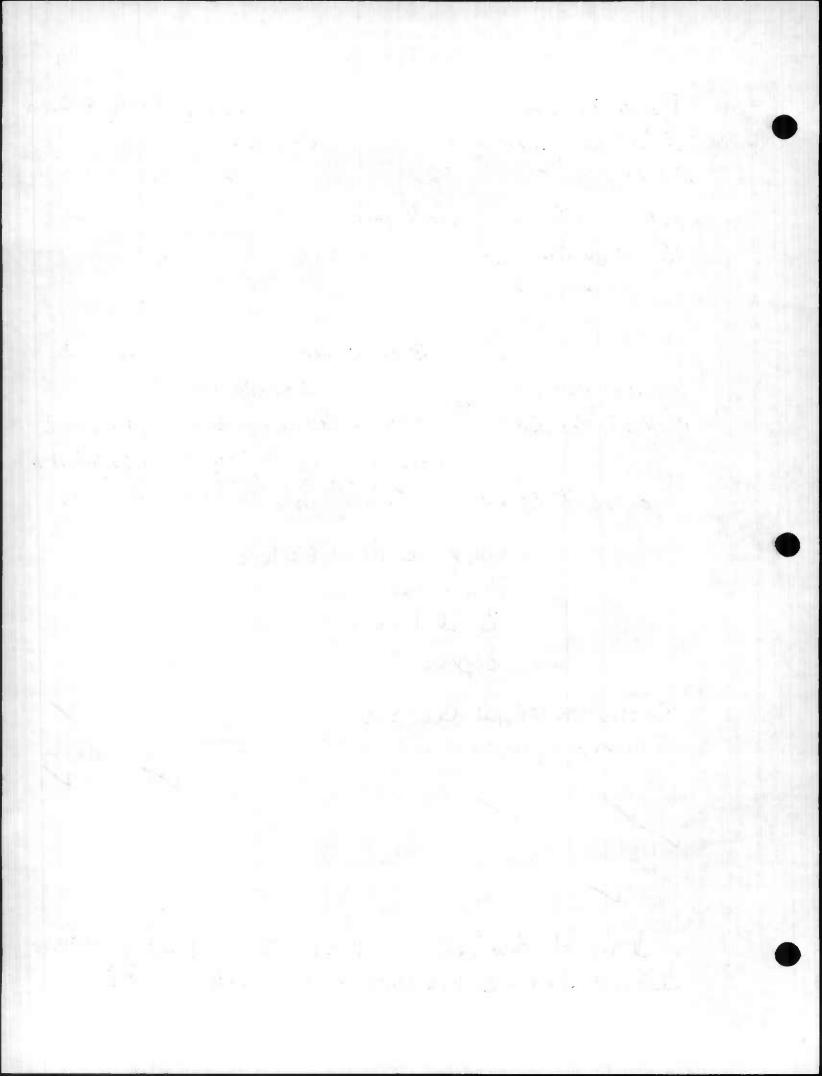
State of Maryland / Department of Health and Mental Hygiene 8 02033

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Examir	ier		Jursing Hon	10	4	Battimo		4c. County of	Deeth	,
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday) If Und	ler 1 Yeer	If Under 24 Hrs.	B. Date of Birth		9. Birthple	ece (Stete or For
Director	0	218-12-4807	M 20FF	76 Yrs. Month	s Deys	Hours Min.	Month, Dey,	1921	Ma	ryland
Mo III		Usuei Residenca of Decedent 10a. State 10b. County	10c. Çir	7. Town or Location					10	d. Inside City LI
48	to	md N/a		altimor	e					1 Yes 2
284 F. Total	Director	10e. Street end Number			Zip Code		10	g. Citizen of W	het Counti	y?
23s or 28s-f show	al	5508 Norwe	ood ave -		212	07		415	9	
items ner m	Funeral	11. Marital Status	12. Wes Decedent Ever In U. Armed Forces?		edent of His	spenic Origin? (Spec n, Mexican, Puerto R	ify Yes or No- ican, etc.)		- Americe	
0	by F	1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:	1 ☐ Yes	212 No	Specify:		0		
etural' sal Ex	Pe	15. Decadent's Ed	lucation	16e. Decedent's Us	suel Occupa	tion	1	6b. Kind of Bus		nericul
Med n	Completed	(Specify only highest grade Elementary/Secondery (0-12)	de completed) College (1-4or 5+)	(Give kind of v	vork done d use retired)	uring most of working	7		,	
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nd Mental Hygiene. marked othar than imatic event, tha M	2	SIEVEN UCINUO 19e. Informent's Neme/Relationship (7	right	10h Mailing Addes	no (Ctront o	Marina	Phill	IPS		2
8 8 8		Mr. John Hines	YOU, FINISHUSBAND			nd Number or Rural	HIMORE			_
y or		20a. Method of Disposition		lece of Disposition (A	ONWOO			Oc. Location - C		
		1 1 Burial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specify	Hemover from Stete	ametery, cremetory of	/	1/	13/98 6	wings	m.11.	s mn
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hysician end the buriel-transit	Examiner	Sequentially list conditions.	U	r es e consequenca of		3404 040				
slan e	Ě	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury								
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by the techer	Physician	Pert II. Other eignificant conditions co	minibuting to death but not rest	iiting in the underlying	cause give	n in Pert I.		acco uee cont 2□ No	ribute to t 3 ☐ Proba	./
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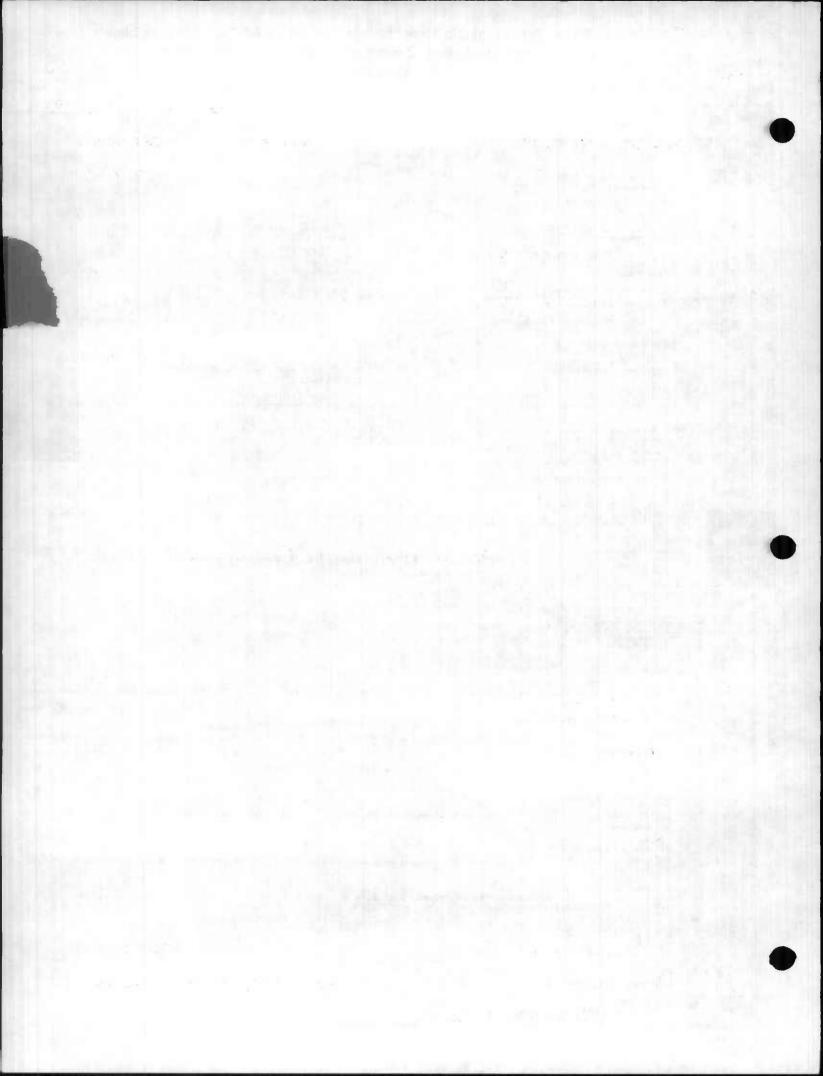


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			Certificate of Death	Reg. No.	02004
Physic	ian	Decedent's Neme (First, Middle, Last)		2. Date of Deeth Month Day+	3. Time of Death
/Medi		15el UM Hairstn		JANUARY 16"	1998 8: 30 bw
Exami	ner	4e. Facility Neme (If not institution, give street and number)	4b. City, Town, or Loc		of Death
		HOII Secours Hospilal		iore n	19
Funeral Director		5. Social Security Number 6. Sex 17. Age (In yrs. In Usuel Residence of Decedent	2 Yrs. Months Deys Hours Min.	8. Date of Birth (Month, Dey, Yeer) 02-28-1925	9. Birthplace (State or Foreign Country) NOTTH Carolly
yland		10a. State 10b. County 10c. City	, Town of Location		10d. Inside City Limits
h the Maryland r 28a-f show	ctor	Md N/a 13	altimore		12 Yes 2 □ No
th with	Funeral Director	1306 N. Bentalou St	10f. Zip Code 21216	10g. Citizen ot Wi	hat Country?
ter dea	Jue	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No	S. 13. Was Decedent of Hispenic Origin? (Spelt Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.) 14. Race	- Americen Indian, , White, etc.
21215-0020 d within 72 hours after deligione. r than "naturel", or flems	by	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify	,
	Completed	15. Decedent's Education (Specify only highest grade completed)	18e. Decedent's Usuel Occupetion (Give kind of work done during most of workin life. DO NOT use retired)	16b. Kind ot Bus	siness/industry
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "any Injury or other treumetic event, the Manage.	m	Elementary/Secondary (0-12) College (1-4or 5+)		10170	
, Maryland 212: Ind 2 should be filed within all the Mental Hygiene. 27 is marked other then or treumatic event, the Mental Ment		17. Fether's Name (First, Middle, Last)	Truck Driver	(First, Middle, Meiden Sumeme	wan Co.
d be sand and and and and and and and and and	Be C	1121/1/2000 Michael		- 11' +	,
Maryland d 2 should be file the end Mental Hy 7 is marked oth treumatic event	10	19e. Intorment's Name/Relationship (Type, Print) (WIFE)	19b. Mailing Address (Street end Number or Rure)		State Zin Code)
Magarian Mag		Mrs Pacalia Haratan	1201 NI Montal	101	M - 7 1 - 1 /
or Health Item 27 other tr		20a. Method ot Disposition 20b. Pl	ace of Disposition (Neme of	pate 20c. Location - C	Olty or Town, State
altimore mit. Pages 1 a partment of He portant: If item y Injury or othe			arrison forest 1/	122/98 Owing.	5 Mills MD
Baltimo permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee		222 W. Marh	
Departition of the policy of t		band & Day	JOSEPH RUSS		-21216
		23a. Part. Enter the disease, or complications that caused the death	Do not enter the mode of dying, such as cerdiac or		Approximete
Physiclan		23a. Part. Enter the disease, or complications that caused the death nock, or hear tailure. List only one ceuse on each line.		,	Intervel Between Onset end Deeth
/Medical		Immediate Ceuse (Finel disease or condition CON ORA	ive Heart Failure	0	
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X OX Sentifice		. sepre	2		
BOX eath cert attendin for use	Physician				
bat the de de by the detached	ysic	Pert II. Other significent conditions contributing to death but not result		23b. Did tobacco use cont	ribute to the cause of death
	by Pr	Gastro Intertual BL	EEDING	1 Yes 2 No	3 Probably Dunknow
ros quires n sign		TILENIARRANIA		24e. Wes en eutopsy	24b. Were eutopsy tindings
w require been si should	Completed	THEOM BOCY to DENIA		performed?	eveilable prior to completion of cause of deeth?
he la e has	шо			1 ☐ Yes \ 2 No	1 □ Yes 2 No
OT VICAL RECORDS, Physician: The law requires the certificate has been signeral director, page 2 should be	0	25. Was cese reterred to medical	26. Plece of Deeth		TE TES THO
Of VITA Physician: This certific	To B	examiner? Hospital:	Other:	ne 5 ☐ Residence 6 ☐ Other	(Specify)
er thi		27. Manner of Death 28e. Date of Injury	28b. Time of 28c. Injury et 2	8d. Describe how injury occurre	
Attending ar death. ector: After by the fune	atio	1 Neturel 5 ☐ Pending (Month, Dey Year) 2 ☐ Accident Investigation	Injury Work? M 1 Yes 2 No		
DIVISION or Attending after death. Director: After	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At hor building, etc. (Specify,		28f. Location (Street end Number City or Town, Stete)	r or Rurel Route Number,
e Dia fi	Cer	building, see. (obserty)		ony or roun, ololo,	
lospi uner uner	edicai	29a. Certifier (Check only 2 Medical Examiner: On the best of exeminating the control of the best of t	rledge, deeth occurred et the time, date end place, et on end/or investigation, in my opinion, death occurre	nd due to the ceuse(s) end men	ner es steted.
To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		one) and menner steted.			
N Viti	Σ	29b. Signature end title ot certifier	29c. License number	> 0	(Month, Dey, Year)
Y		Jerance d. d'ant no	D3+203	JANUANU	1171 1978
Q		30. I) ame end eddress of person who completed cause of deeth (Item	23e) (Type, Print)	Baltimore 1	mal
		Thursd J. Sant-M.D 1861	3600	pour more	
Sta Registr		31. Date tiled (Month, Day, Year) 32. Registrer's Signet	K:1 S		

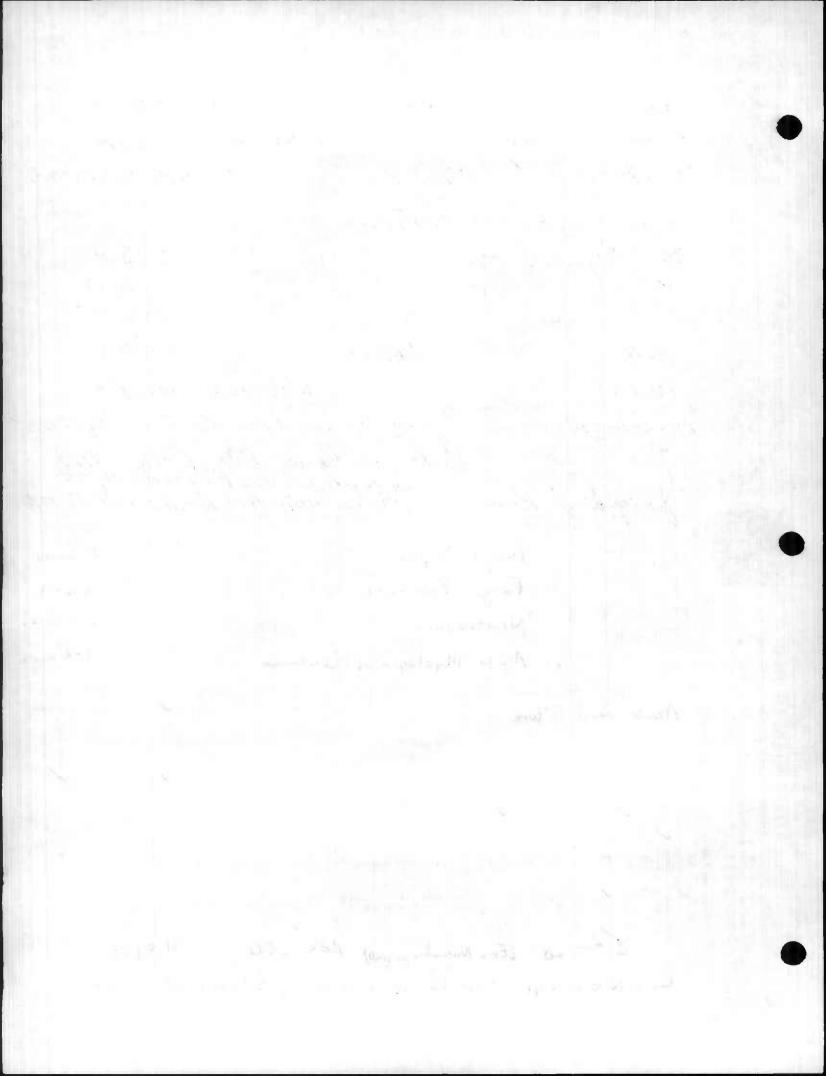


	EVI UDSON		State of Maryland / Department of Health and Certificate of Death		giene Reg. No. 98	02035
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8	Funeral Director		WASHINGTON COUNTY HOSPITAL 5. Social Security Number 6. Sex 108 M 2 F 7. Age (In yrs. last birthday) When the property of	s. 8. Date of Bit	WASHII	NGTON 9. Birthplace (State or Foreign Sountry) Maryland
	Be-f show	Director	10e. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
215-0020	within 72 hours after death with the Manyland ena. than "natural", or items 23a or 28a-1 show ha Madeal Examiner must be morified at	by Funeral	11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, specify Cuban, Mexicen, Pue If Yes, Specify: 1 Yes 2 No If Yes 2 No	(Specify Yes or No arto Ricen, etc.)	Specify	S American Indien, k, White, etc.
2	L	Completed			Hosp	rtal
Maryland	should be nd Mental marked o	To Be		ame (First, Middle	igham H	Hudson
-	Haalth em 27		Ms. Sylva Hadson 20e. Method of Disposition 1 Deburial 2 Cremetion 3 Removel from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other place)	Baltimo Date		21224 City or Town, State
Baltimore	permit. Pagas Department of Importent: If It any Injury or one		21. Signature of Funerel Service Licensee 22. Name and Address of Facility	222: Batti	nore, ind	thave
68760,	se be	dical Examiner	Ceuse (Disease or injury that initiated events Due to (or as e consequence of):			Approximate Intervel Between Onset end Death
P.O. Box	The law requires that the death certifical its has been signed by the attending phyage 2 should be detached for use as the	by Physician/Med	d. Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. Diabetes mellitus			ntribute to the cause of death?
of Vital Records,	e law requira: has been sig ge 2 should b	Completed b	Diabetes mellitus Lymphoma		s en eutopsy omed?	24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth?
f Vital F	certifica rector, I	To Be Cor	25. Wes case referred to medical assuminer?	1 € Peeth (Check only 1 Home 5 ☐ Res		1Æ Yes 2□ No or (Specify)
Division o	To the Hospital or Attending Physicians, within 2 hours after death. To the Funeral Director: After this complately filled in by the funeral director.	Certification:		28f. Location	how injury occurr (Street end Numb wn, State)	er or Rural Route Number,
	the Hospita nin 24 hours the Funeral	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phyelclen: To the best of my knowledge, deeth occurred et the time, date end pla 2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end pla 2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end pla		, date end place, e	end due to the ceuse(s)
	To Too	M	Dennis J. Chute, no O.C.M.E.		JANUARY	13, 1998
	Sta	te	30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Dennis J. Chute, MP 111 Penn Street 31. Date filed (Month, Day, Year) 32. Registrer's Signature	et, Balti	more, Ma	aryland 21201
	Registr					



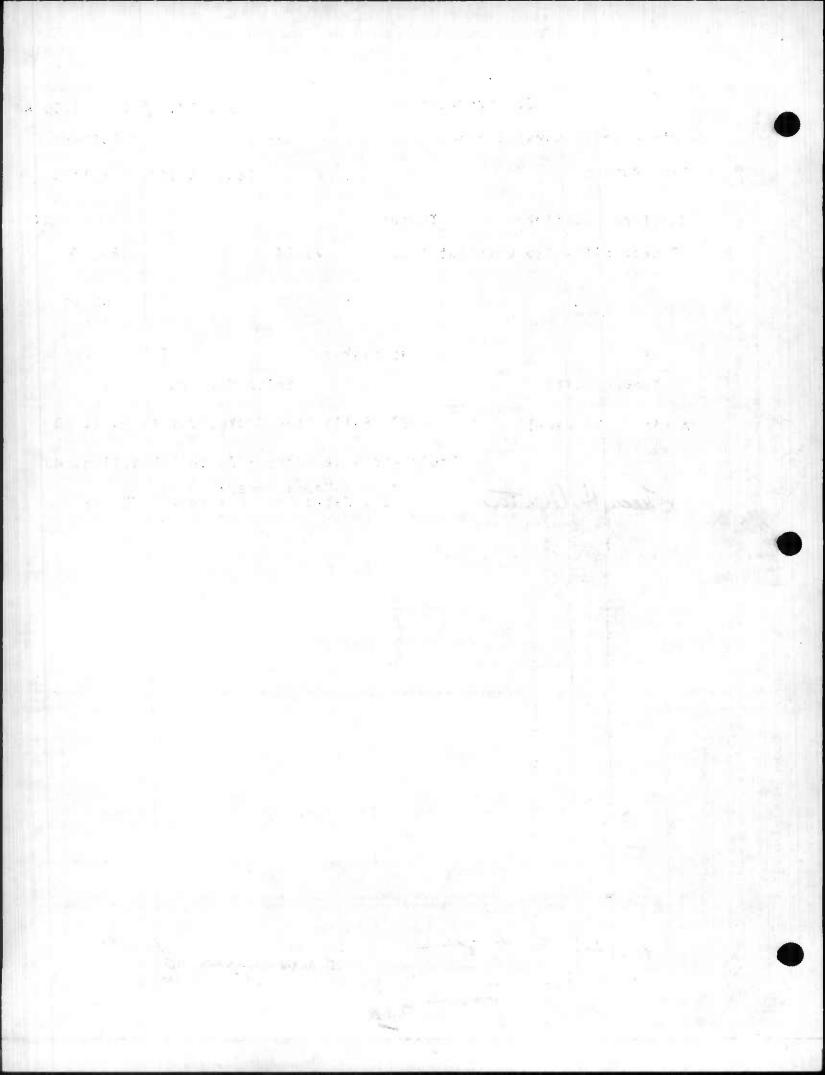
State of Maryland / Department of Health and Mental Hygiene 9 8 0 2 0 3 6

				Cer	tificate of	Death	F	leg. No.							
Physician		1. Decedent's Name (First, Middle, Las	1)				2. Dete of Dee Month		3. Time of Deeth						
/Medical		YOLANDA		HICKS			JANUARY	17,1998°	1:26AM						
Examiner	-	4e. Fecility Neme (If not institution, give THE JOHNS HOPKINS				4b. City, Town, or BALTIMOR		4c. County of I	Deeth						
Funeral Director	0	5. Social Security Number 6. Social Security Number 11 201-41-94-14 Usuel Residence of Decedent	7. Age (In yrs. I)	est birthday) Yrs.	If Under 1 Year Months Deys		8. Dete of Birth (Month, Dev	Yeer) 9 -1970 K	Birthplace (State or Fore gountry)						
the nutflied at	PCTO	10a. Stete 10b. County MAYYIANO 10e. Street end Number	A 10c. City	Alli	more				10d. Inside City Lim						
23e or 3	מו חוב	3518 HAYWA	rd Ave.		10f. Zip Code	15		log. Citizen of Whe	S.A						
urel', or items 23e or 28a-f show at Examiner mant be incitted at cd by Funeral Director	2	11. Marital Status 1 ☑ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 277 No If Yes, Give Yeer or Detes:		Vas Decedent of Yes, specify Cub	Hispenic Origin? (S pan, Mexican, Puer Specify:	pecify Yes or No- o Rican, etc.)	14. Raca - Black, Specify:	American Indien, Alphy.ejc-O Prical						
I fleath and Mental Hygiene. Item 27 is marked other than "naturel;, other traumatic event, the Medical Exp. To Be Completed by	Completed	15. Decadent's Ed (Specify only highest green Elementary/Secondery (0-12)	ucation de completed) College (1-4or 5+)	16e. Deced (Give life. L	ent's Usual Occu kind of work done DO NOT use retire	pation during most of wo	rking	FACTO	-						
marked other than " imatic event, the Me To Be Comple	0 00	17. Father's Neme (First, Middle, Last)	Ameron			.) [me (First, Middle,	Meiden Sumeme)	Ks						
end s	1	19e. Informent's Name/Relationship (7	ype, Print) (mother)	19b. Mailin	g Address (Stree	t and Number or Ri	rej Route Numbe	r, City or Town, Ste	ite, Zip Gode)						
Department of Health er Important: If Item 27 is any injury or other traugonce.		20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify 21. Sometime of Funeral Service Licenses)	Removel from State 65	shell	sition (Neme of party) or other play (Nem of Addt)	pss of acitien	12/98 55 Fu Ave, B	20c Location - Cit BAITU NETAI	y or Town, State Mc Home e Md 212						
ysician Medical caminer		Immediate Ceuse (Final disease or condition resulting in death)	e Fungal S	epsis		ng, such es cardie	c or respiretory en	est,	Approximete Intervel Betweer Onset end Deeti						
n and ial-transit Examiner		Sequentially list conditions	D	es e conseq					I wee						
sician ar bunial-t		Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that injured events.	· Neutrope	inia					2-3 we						
	vmedical	/Medicai	/Medic	Medic	Medic	Medic	VMedical	thet initieted events resulting in deeth) Lest		es e consequ neloge		enkemia			1-2 m
ned by the ettend deteched for us y Physiclan	yalcia	Pert II. Other significant conditions co	ntributing to deeth but not resu	Ilting in the ur	nderlying cause gi	ven in Pert I.	23b. Did to	obecco use contri	bute to the cause of de						
igned by be detected		Acute Renal Fa	ilure				1 🗆 Y	es 202 No 3	☐ Probably 4☐ Unk						
hould be							24a. Wes e perfor		24b. Were eutopsy finding eveilable prior to completion of cause of deeth?						
s certificate hes bilirector, page 2 s	5						1 🗆 Y	es 2 No	1 ☐ Yes 2 No						
director,	D	25. Was case referred to medical exeminer?				26. Plece of De	eth (Check only or	ne)							
		1 ☐ Yes 2 ☑ No		ER/Outpetien	I 3□ DOA Ot	her: 4 Nursing H	lome 5 Resid	enca 6 🗆 Other (Specify)						
= @		27. Manner of Deeth 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28e. Dete of injury (Month, Dey Year)	28b. Time of Injury	28c. Inju Wo M 1	ny et ork?] Yes 2 □ No	28d. Describe h	ow injury occurred							
Direct of in by		3 Suicide 6 Could not be determined	28e. Plece of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, offica		28f. Location (S City or Tow		or Rural Route Number,						
within 24 hours effer death. To the Funeral Director: Affer this completely filled in by the funeral Medical Certification: 1		29a. Certifier 1 Certifying Phy cone) 1 Medical Exam	sician: To the best of my know iner: On the basis of examinet end manner steted.	vledge, death lon end/or inv	occurred et the ti estigetion, in my	me, dete end plece oplnion, deeth occu	e, end due to the coursed et the time, co	ause(s) end menne dete end plece, end	er es steted. I due to the ceuse(s)						
To the company		29b. Signeture end title of cartifier			29c. Licen			29d. Date signed (A	fonth, Dey, Year)						
		30. Name end eddress of person who c	(Eric Nuer	mberger	,mb) R	ES-00	0	1181	48						
+		Eric Nuermbe	roex Tower 11	10.60	DN. W.	Ife S+ 1	Baltimore	MD 2	1227						
State Registrar		31. Dete filed (Month, Day, Year) JAN 28	32. Registral's Signat	ardsen-	Andree										



State of Maryland / Department of Health and Mental Hygiene 8 0 2 0 3 7

					Ce	rtificate	e of	Death		Re	g. No.	0 4	.007
Physic	ian	Decedent's Name (First, Middle, La	E. Ca	theri	ne He	e i l		,		. Dete of Deeth Month	Dev	Yaar O O	3. Time of Death
/Medi Exami		4a. Fecility Neme (If not institution, given Pickersgill N	e street and number	9r)				4b. City, Town			4c. County		6:25 Al
Funeral Director		5. Social Security Number 6. S 2 1 3 - 4 8 - 2 1 3 2 Usuel Residence of Decedent	6ax 7.		last birthday) 96 Yrs.	If Under Months	1 Yaar Days		Min.	Dete of Birth (Month, Dey, eb. 26	(ear) , 1901	Count	lece (Stete or Foreign try) yland
a-f show diled.st	ctor	10a. Stata 10b. County	imore		y, Town or Lo		Ī					10	0d. Inside City Limits 1 ☐ Yes 2√0√No
23a or 28 ust.be.no	Funeral Director	10e. Sfreet and Number Pickersgill-	515 Che	stnut	Ave.	10f. Zip	Coda	21204		10	g. Citizen of V	What Counf	iry?
72 hours after death with the Maryland natural, or items 23a or 28e-f show dical Examinat must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Wes Deceder Armed Force 1 Yes 25 If Yes, Give Yeer or Date:	s? ĮNo		Was Deced If Yes, spec 1 ☐ Yas 2		Hispanic Origin een, Mexicen, I Specify:	n? (Speci Puarto Ri	fy Yas or No- can, etc.)		e - Amarica ck, White, e	
within 72 hours ane. than "natural", he Medical Exa	Completed	15. Decedent's Ec (Specify only highest gre Elementery/Secondary (0-12)	ducetion de completed) College (1-4c	or 5+)	(Give life.		k done e retire	during most o	of working	10	Sb. Kind of Bu		
id be filed fental Hygie feed other its event, the	To Be Co	17. Father's Name (First, Middle, Last) Clarence Lit			пс	mema	кег	18. Mother's		First, Middle, Ma	iden Sumem	0 w n	Home
and 2 sho eaith and N in 27 is man her fraume				a w	1300)1 Fa	119			Route Number,	-		
permit. Pages 1 Department of H Important: if he any injury or of obse.		20e. Method of Disposition 1 □ Suriel 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specify	()	te C		lidge	Ce	emeter	1		Pike		n, Stete
Depa Depa Impo any is		23a. Part1. Enter the bisaase, or comshock, or heer allure. List only	spenter		B 3	urge 631	e-Fal	1s Ro	ad I	eral H Baltim	ore.		1211 Approximete
Physician /Medical Examiner pue uei peinoexe e peinoexe	Examiner	Immediate Causa (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	e. Atte	Due to (or	res a consecuence of es e consecuence of the consec	quence of):	lio :	NASCA CO	e V	i's ever			Onsat and Deeth
eeth certificete be executed ettending physicien end for use es the buriel-trensit	ian/Medical	thet initiated events resulting in deeth) Lesf	d	Dua fo (or	as e conseq	quence of):							
y the d	by Physician	Pert II. Other significant conditions of	ontribufing to death	but not resu	ilting In the u	nderlylng ce	ouse gi	ven in Pert I.			ecco use cor 2.≊No		the cause of death?
aw raquas basen 2 shoul	Completed b									24e. Wes an performe	eutopsy ed?	com	re eutopsy findings illeble prior to inpletion of causa leeth?
The Base	Be	25. Wes cese referred to medicel examiner?							f Deeth (0	1 ☐ Yee	\$ <u>₹</u> 100	10	Yes 2□ No
ing Phys	Certification: To	27. Menner of Deeth 1. Naturel 2 Accidenf 3 Suicide 4 Homicide	28e. Plece of i	jury Jey Year)	ER/Outpetier 28b. Time of injury	f 28	Bc. Inju Wo 1		280	5 ☐ Residend Describe how Location (Stre City or Town,	injury occurr	ed	
To the Hospital or Attend within 24 hours efter dealt To the Funeral Director:: completely filled in by the	edicai Cer		rsician: To the bes	t of my know of examineti	viedae, deeth	occurred e	t the ti	me, dete end p	plece, end	I due to the ceu	se(s) and ma	nner es ste	eted. the ceuse(s)
To the To the comple	2	29b. Signeture and title of certifier	end manner :	stated.		.29c.	Licens	se number		290	Dete signed		
1		30. Neme and eddress of person who of 10629 900. 31. Date filed (Month, Dey, Year)	completed ceusa of	death (Item	23a) (Type,	Print)	J.	ALAN	BALL	SANZA.	1030		
Sta	te	31. Date filed (Month, Dey, Year)	32. R	tanda Signat	Ura Ca	0 00							



State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Year **Physician** Giovanina Heddinger January 26 1998 1:45 PM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner 7516 Holabird Ave Dundalk Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Dey, Yeer) 5 Social Security Number 6 Sax 7. Age (In vrs. lest birthdev) Birthplece (State or Foreign Country) **Funeral** Days 1□M 2XF 62 213-32-1813 May 19 1935 Director MD Usuel Residence of Decedent the Maryland r 28a-f show 10a State 10h Counts 10c. City. Town or Location 10d Inside City Limits MD Baltimore 1 Tyes 2 N No Director Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with "naturel", or items 23a or 7516 Holabird Ave 21222 USA Pages 1 and 2 should be filed within 72 hours efter deeth nent of Health and Mental Hygiene.
nt: If Item 27 is marked other than "naturel", or Itema 23. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien. Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "natur traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondery (0-12) 1 2 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Luigi Tagliaferri Assunta Fabian 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 7516 Holabird Ave Ronald Heddinger /husband Baltimore, MD 21222 other 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Jan 29 20c. Location - City or Town, Stete permit. Pages Depertment of Important: If it any injury or o 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) Sacred Heart of Jesus 1998 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home of Dundalk oct 7110 Sollers Point Rd 21222 23a. Pert1. Enter the discusse, or complications that caused the deeth shock, or heart feilure. List only one cause on each line. not enter the mode of dying, such as cerdiac or respiratory arrest, Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in death) ANCREatic CANCER 6 m Examiner Due to (or es e consequence of) Examiner physician end the buriel-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es a consequence of): attending p signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 Yes 2 No 2 24b. Were autopsy findings eveileble prior to been si 24a. Wes an autopsy performed? Completed completion of ceuse of deeth? certificate has b 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: diractor, Be 25. Was case referred to medice! examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After 5 Pending investigation 1 Neturel death. 1 ☐ Yes 2 ☐ No 2 Accident Director 3 ☐ Sulcide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) á 4 Homicide 29a. Certifier 🖆 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner as steted. Medical (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) end menner steted. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Dete filed (Month, Day, Year)

32. Registrar's Signature Johia Davidson

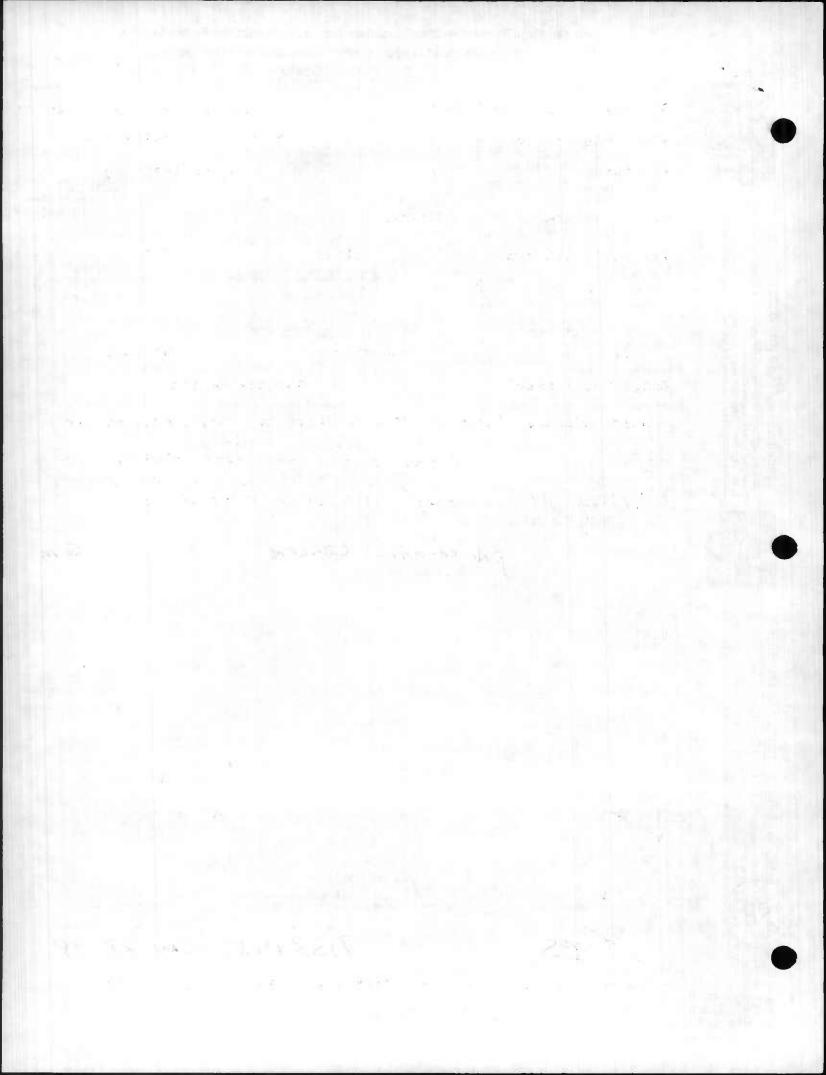
2801 Foster Ave

Baltimore, MD 21224

30. Neme and eddress of person who completed ceuse of death (Item 23e) (Type, Print)

Kenneth Williams, M.D.

JAN 28 1998



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month January 24, 1998 Joyce Sanford Jennings **Physician** 3:53 PM /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Baltimore City Johns Hopkins Bayview Medical Ctr. If Under 1 Yaar 8. Date of Birth Nov. To, 1927 5. Social Security Number 7. Age (In vrs. lest birthdev) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours Min 1 □ M 2 X E 70 Yrs 227-28-9770 Virginia Director Usual Residence of Decedent with the Marylend 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23s or 28s-f shot treumstic event, the Medical Examiner must be notified as Dundalk Baltimore Maryland 1 Yas 214No Director 10e. Street and Number 10f. Zip Code 10a, Citizen of Whet Country? 21222 United States 7402 School Avenue Peges 1 and 2 should be filed within 72 hours efter death vent of Health and Mentel Hygiene.

In it: If team 27 is marked other than "natural", or items 23 mir: If team or other treumsite event, the Medical Execution must Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 💆 No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 14. Race - Amarican Indien, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 If Yes, Give Year or Datas: 1 Yes 2 No Specify: Specify: White Àq 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 Years 18. Mother's Name (First, Middle, Maiden Sumama) 17. Fathar's Neme (First, Middle, Last) Marian Sanford Athel Hall 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Mr. Roy V. Jennings/Husband 7402 School Avenue Dundalk, Maryland 21222 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cramation 3 Removal from State Department of Important: If any Injury or 4 Donetion 5 Other (Specify) Garrison Forest V.A.Cem.1/28/1998 Baltimore, Maryland Wrat Service Licen 22. Neme end Addrass of Facility 21. Signature of Fi Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part. Enter the disease, or complications that caused tha deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heef failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) TURMOMAI Examiner CERE BLOVALWIAR ACEIDENT WITH HEMIREGIA Examiner physician end s the buriel-transit thet the death certificate be executed Sequentially tist conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): RTEMSION P.O. Box 68760 Physician/Medical Due to (or es a consequence of): for use es t EIZURE signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records. þ 24b. Were eutopsy findings eveileble prior to completion of cause Completed 24e. Wes en eutopsy ate hes t 1 ☐ Yes 2 ☑ No 1 Yes 2 No certificate Hospital or Attending Physician: funeral director. Be 25. Was cese referred to medical exeminer? 26. Plece of Daeth (Check only one) 20 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpetient 3 DOA After this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation Neture efter death. 1 🗌 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital of within 24 hours of To the Funeral D completely filled it 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

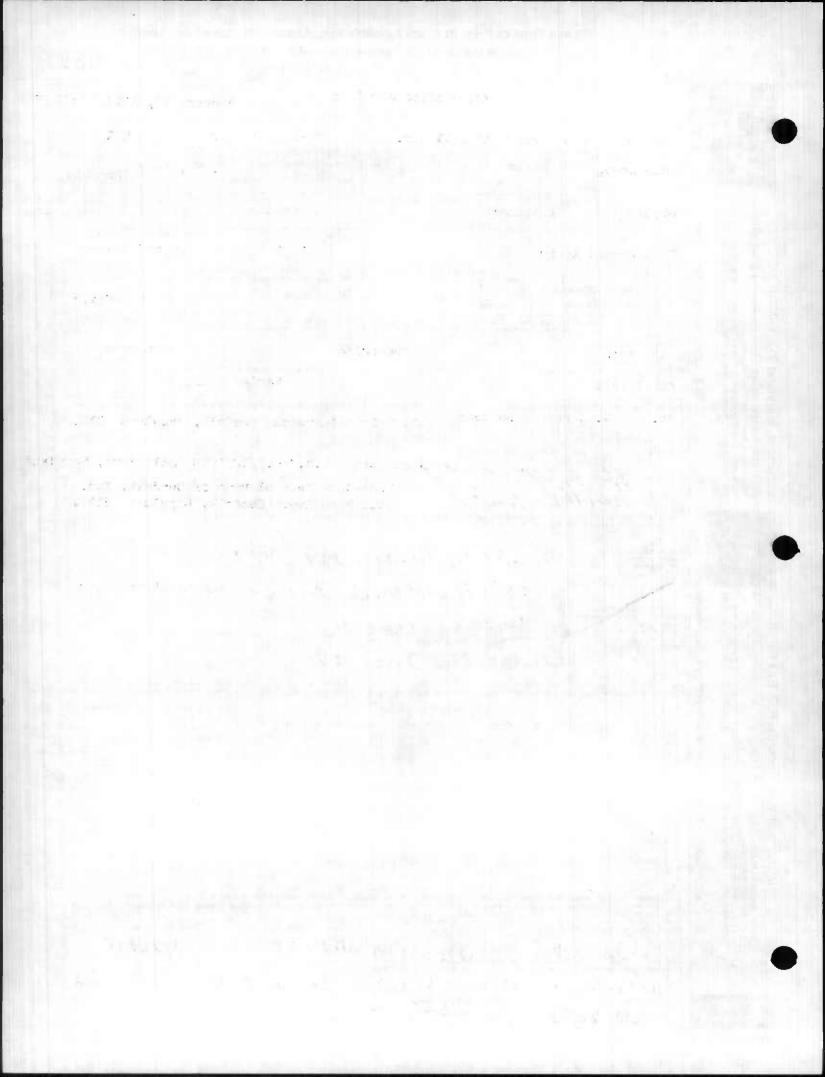
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end manner steted. 29e. Certifie edical 29c. Licanse number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 30. Name end eddress of person who completed cause of deeth 23e) (Type, Print) Place annderle

329 Registraris Signature Prindale

State Registrar 31. Data filad (Month, Day, Year)

JAN

28 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene of Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day 21, 1998 Month Tonke 22:28 EDWAR D January # Long, Baltimore City

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Admits Days Hours Min. Sept 201922 4e. Facility Nema (If not Institution, give street and number) 4c. County of Death The Johns Hopkins Hospita 6. Sax 12 M 2□ F Birthplaca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 277-16-681 Yrs Usual Rasidance of Decedant 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No 10e. Straat and Numbar 10f. Zip Coda 10g. Citizan of Whet Country? 56/0 WRIVE 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atç. 11. Marital Status 1 ⊠Yas 2 □ No If Yas, Giva Yeer or Datas: WWII 1 Navar Married 2 Married 1□ Yas 25 No Specify: While 3 ☐ Widowed 4 ☐ Divorced 15. Dacedent's Education (Specify only highest grade complated) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 12YRS 4488 17. Fathar's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Steta 1 Burial 2 Cramation 3 Removal from Stata
4 Donation 5 Othar (Specify) 21. Signeture of Funeral Sarvice Licansee Harterd 23a. Part 1. Entar tha disaasa, or complications that caused the deeth. Do not entar tha mode of dying, such es cardiac or raspiratory shock, or haart failura. List only ona causa on aach lina. Approximata Intarval Batween Onsat and Death Immadiete Causa (Final disaasa or condition rasulting in daath) Stant 2 weeks Sequantially list conditions, if any, leading to Immediata ceusa. Entar Undarlying Causa (Disaasa or Injury that Initieted avants resulting in daath) Last Dua to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown none 24b. Wara autopsy findings available prior to complation of cause of daath? 24a. Was an autopsy parformed? 1 Yas 2 No 1 Yas 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stata

Director

Funeral

þ

Completed

Funeral

Director

permit. Peges 1 end 2 should be filed within 72 hours after death with the Manyland Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "netural", or items 23e or 28e-f show any Injury or other tranmatic event, I'm Medical Exerting must be notified at

altimore, Maryland 21215-0020

Examiner Physiclan/Medical þ Completed 2 Certification:

25. Was cesa rafarred to medical axaminar?

1 Yes 22 No

31. Date filed (Month, Day, Year)

JAN

27. Mannar of Daath

1 Natural

The law requires that the death certificate be executed ettending physician and for use es the burial-transit signed by t funeral director, this ofter death Director: 5 Hospital

Division of Vital Records, P.O. Box 68760,

To the Hospital within 24 hours To the Funeral I Medical

State Registrar

invastigation none 2 Accidant 6 Could not be datarmined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

Madical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the causa(s) and mannar stated. 29a. Cartifiar (Check only one) 29b. Signatura and titla of certifier

5 Panding

28 1998

28c. Injury at Work?

1 Tas 2 No

26. Placa of Daath (Check only one)

Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify)

28d. Dascribe how Injury occurred

29d. Data signad (Month, Day, Year) January 21, 1998

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Morgan

Howland Wol 600 North

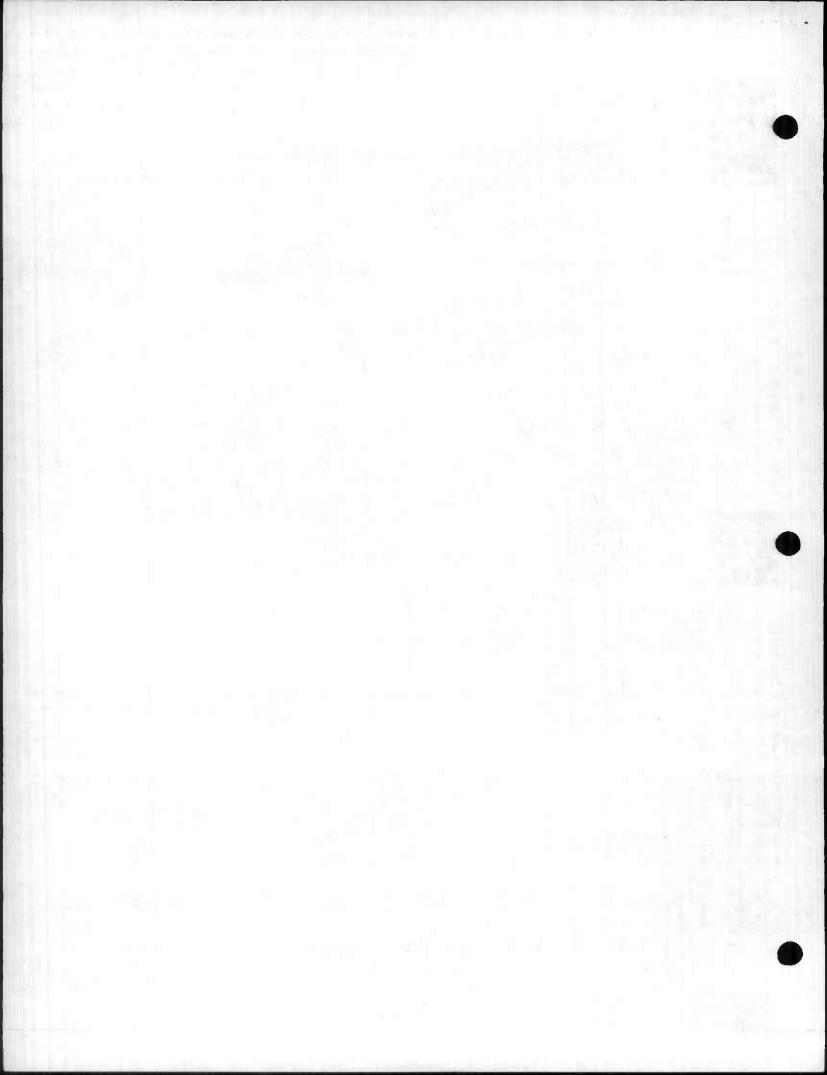
28a. Data of Injury (Month, Day Year)

Baltimore, MD 21287-9106 e Street

32 Registrar's Sign

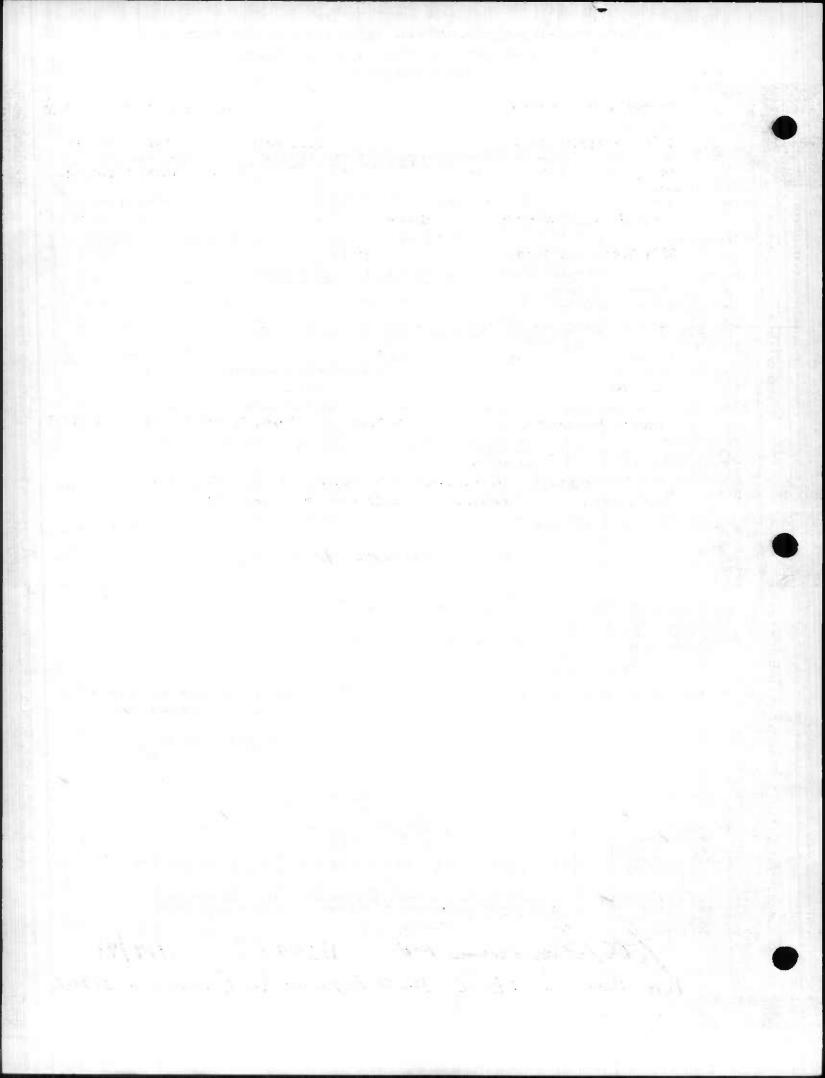
1 Inpatient 2 □ ER/Outpatient 3 □ DOA

28b. Tima of



State of Maryland / Department of Health and Mental Hygiene 98 02041

sicia	_	1. Decedant's Nema (First, Middle, L.				J61 (I	noute	9 01	Death		2. Data of De	Reg. No eath Da		Year	3. Tin	ne of Clearth
edica	-	Robert Joseph J	ohnson								Janua		, 19		9:4	5 AM
mine	_	4a. Facility Nama (If not institution, gi		ber)					4b. City, Tov	vn, or Loc	cation of Deet	h 4c	. County	of Death		
		3804 Dorchester							Balti				Balt	imore		
ral or			Sax 1 DgM 2□F	7. Aga (In yrs. 72			If Under 1 Months	Days		Min.	8. Data of Bi (Month, De April	th 4 , 1	925	9. Birthp Coun Mary	lace (St try) / Lan	ate or Foreig
	-	10a. Stata 10b. County		10c. Cit	y, Town	or Loca	tion							1	0d. Insid	da City Limits
	SCTO		oreCity	Bal	ltime	ore										Yes 2 No
	Funeral Director	10e. Street end Number 3804 Dorchester	Road				10f. Zip (S.A.	What Coun	try?	
	2	11. Maritel Status 1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Deced Armed Ford 1 Yas 2 If Yas, Give Year or Da	ces? 2⊠ No	,S.	It Y	as Deceda 'as, speci	ify Cub	oen, Maxican	in? (Spe , Puarto F	city Yes or No Rican, atc.)	>-		ck, White,	etc.	n,
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	Completed	Elementary/Secondary (0-12) unknown	College (1- unknown	4or 5+)			orer		during most ed)	OI WOIKII	<i>i</i> g	Cor	str	uctio	n	
	De C	17. Father's Name (First, Middle, Las							18. Motha	r's Nama	(First, Middle	, Maidar	Suman	na)		
	0	unknown							unkno	wn						
ı.		19e. Informant's Name/Raietlonship	(Type, Print)			_					l Routa Numb					
		Leonard Johnson	/son						ter Ro	ad,	Baltin	ore,	Ma	rylan	d 21	.215
		20e. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 [4 ☐ Donation 5 ☐ Other (Speci	w in sta	tate	laca of L emetery,	Disposit , <i>cr</i> ame	ion (Nam tory or oti	e of har ple	есе)		Date	20c. L	ocation -	· City or To	wn, Stel	Θ
Make		21. Signature of Funerel Service Lice ROULA TO 23 I. Part1. Enter the disease, or con	West	Direc		Ba	ltime	ore	, Mary	land	l, 655 l 21201		Balt:	imore		mata Between
	medical	Immadieta Causa (Final diseese or condition rasulting in death) Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Causa (Disease or Injury that initiated avants resulting in death) Last	b. DJ	Dua to (or	or as a co	nseque	ence of):	1	DISI	EAS.	E				15	EARS LEAR
8	13 I		d											1		
1 1 1 1 1 1	ysicia	Part II. Other significant conditions	dcontributing to des	th but not rasi	uiting in t	tha und	erlying ca	usa gi	ivan in Part I.		23b. Did	tobacco	use co	ntribute to	the ca	use of death
District Control	Ē	Part II. Other significant conditions	dcontributing to des	ith but not ras	uiting in t	tha und	ertying ca	usa gi	ivan in Part I.			tobacco				
Pier Die seine	Š	Part II. Other significant conditions	d	ith but not rasi	ulting in t	tha und	erlying ca	usa gi	ivan in Part I.		1 □	Yes 2	P No	3 Prol	ara auto	4 Unknow
P. Din.	Š	Part II. Other significant conditions	d	ith but not rasi	uiting in I	tha und	erlying ca	usa gi	ivan in Part I.		1 ☐ 24a. Was perf	Yes 2 s an auto ormad?	P No	24b. Wa	ara auto eilabia p mplatior	4 Unknow
	pe completed by	Part II. Other significant conditions 25. Was casa ratarred to medical examiner?		ith but not rasi	uiting in t	tha und	erlying ca		28. Placa		1 ☐ 24a. Was perf	Yes 2 an autoormad?	Psy No	24b. Wa	ara auto eilabia p mplation deeth?	4 Unknow
To Contract the Contract to Co	o pe completed by	25. Was casa ratarred to medical examiner? 1 □ Yas 2 ☑ No 27. Menner ot Death	Hospital: 1 ☐ In 28a. Date of	patlant 2	ER/Outp 28b. Tir	patient	3□ DO/	A Oti	28. Placa thar: 4□ Nui ury at ork?	of Death	24a. Was peri	Yes 2 san autoormad? Yas 2 ona)	PSy No PSy No 6 □Oth	24b. Was every confirmation of the confirmatio	ara auto eilabia p mplatior deeth?	4 Unknow
To Do Operational Inc. Distriction	o pe completed by	25. Was casa ratarred to medical examiner? 1 □ Yas 2€ No	Hospital: 1 In In 28a. Date of (Month)	patiant 2□	ER/Outp 28b. Tir Inj	patient ma of ury	3□ DO/ 28	A Oth	28. Placa ihar: 4□ Nu ury at ork?] Yas 2□ N	of Death	1 □ 24a. Was perf	Yes 2 s an auto ormad? Yas 2 ona) Idence how inju	No N	24b. We every confirmed arr (Specify red	ara auto eilabia p mplatior deeth?	4 ☐ Unknow psy findings rior to a of cause 2 ☑ No
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State of Maryland / Department of Health and Mental Hygiene o

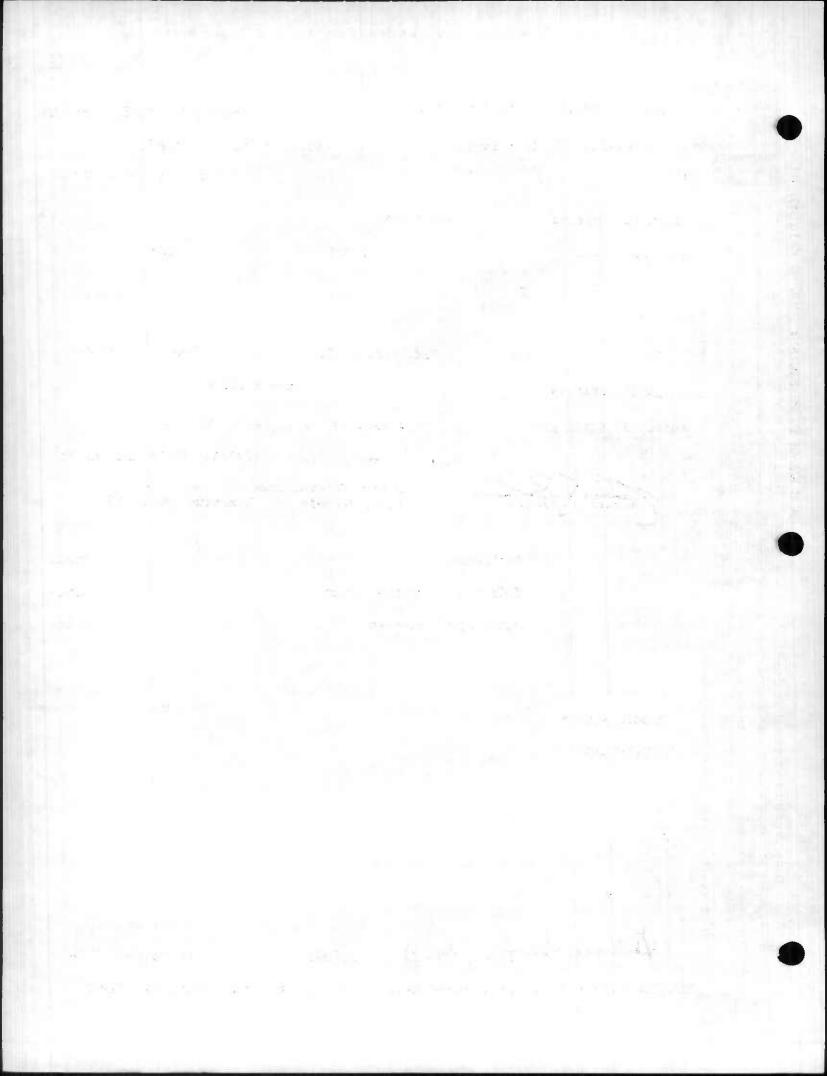
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F		VA Maryland Hea	6. S	n Care S	YS Le M . Aga <i>(in yr</i> s	last bii	rthday)	If Undar 1	Yaar	Perry	PO:	R Dete of B	Ceci		place (Stata or Foraign
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deat	Funeral Director	11. Marital Status		12. Was Daced		J,S.	13. W	as Decedar	nt of H	lispanic Ori	gin? (Sp	ecity Yas or N Rican, atc.)	o- 14. Re		Icen Indien,
1 end 2 should be filed within 72 hours after death with the Maryland Health end Mental Hygiene. Health end Mental Hygiene. Sm 27 Is marked other than "natural", or items 23a or 28a-f show the traumatic event, the Medical Examinat rough be notified at	by	1 ☐ Navar Marriad 2		1 7 Yas 2 If Yas, Giva Yaar or Date	□ No			Tas, specify ☐ Yas 25		Specify:	, Pueno	Hican, atc.)		lack, Whita	
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pemilt. Pages 1 end 2 should be filed within 72 hours Department of Health end Mental Hygiena. Important: If Item 27 Is marked other than "natural", any injury or other traumatic event, the Medical Exa once.	Completed	Elementary/Secondary (0-12)		Collaga (1-4	lor 5+)			ind of work O NOT usa				g		6 -	c
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/Medical Examiner		Immadiata Causa (Final disaase or condition		. Sept	icemia	4								F	1 month
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the da	Physician/	Part II. Other significent condit	ona co	ontributing to deat	th but not ra	sulting i	n tha und	derlying cau	se giv	ran in Pert I.		23b. Did	tobacco use c	ontribute 1	to the cause of death?
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DHMH 16 Rev 6/95

NAME KNOWN TO PHYSICIAN: PAUL M. KAILING,

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

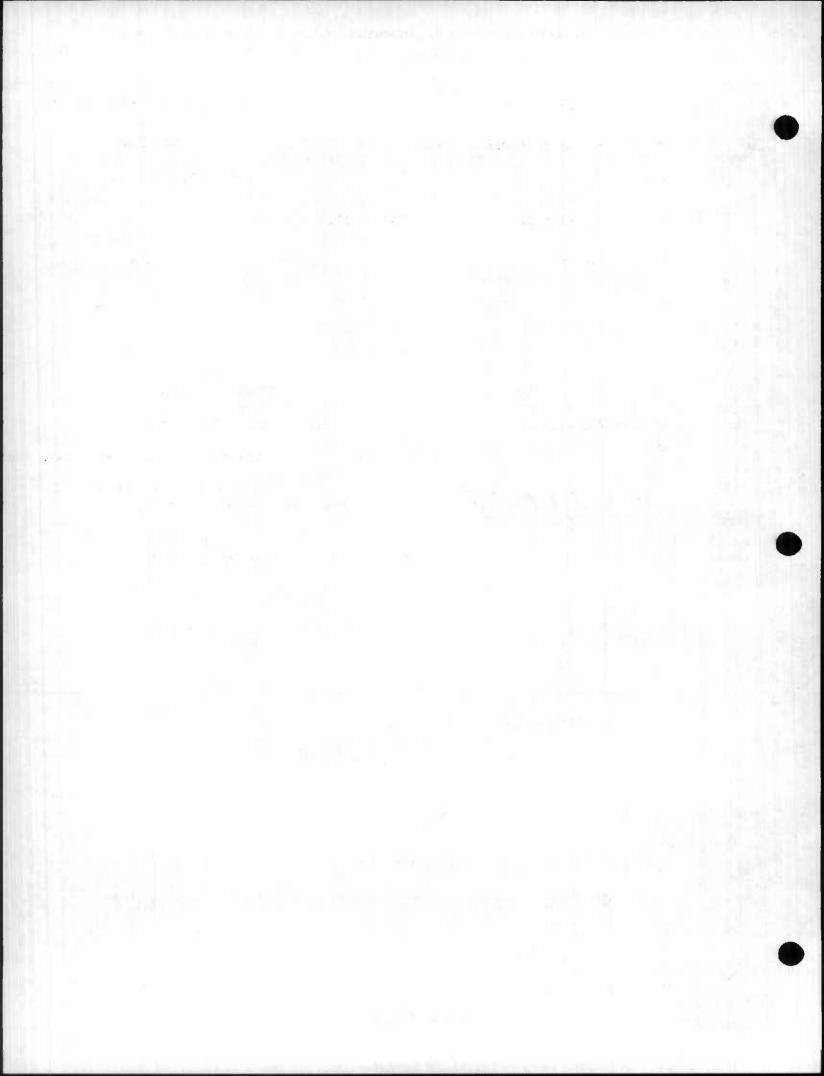
						C	ertifica	ate of	Death		Reg. No.	U U	2043
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ortant: if flem 27 ortant: if flem 27 injury or other to 8.		20a. Method of Disposition 1 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other				cemetery,	sposition (A crematory o	r other ple	tery 1/	Date / 30/98		on - City or To Lmore	own, State , Maryland
uspanman Important: any injury once.		21. Signature of Funeral Servi	oe Licer	9.0	ul	+	22 Name LERO 4600	And Addr	DYETT BERTY H	& SON EIGHTS	FUNEF AVE.,	RAL HO	OME, P.A. O. 21207
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	edical	29a. Certifier (Check only one)	ying Phy af Exam	vsician: To the bas iner: On the bas and manne	is of examina	wledge, de tion end/o	eath occurre r Investigation	ed et the ti	me, date and plac opinion, death oc	ce, end due to the curred at the time	ceuse(s) and date and ple	manner as s ce, end due t	itated. o the ceuse(s)
Too Long	5	29b. Signature and title of cert 30. Name end eddress of pers Justina Wu, 30	fier C. U	Vu, Ir	nterr	1	2	RE	se number	00	29d. Date signal	gned (Month,	Day, Yeer) 1998
U		30. Name end eddress of pers Justina Wu, J	on who co	empleted cause Hapkins	of death (Iter	tal, (pe, Print)	orthu	Joife Stre	et, Balt	more,	Mary	and, 21287
State	•	31. Dete filed (Month, Day, Ye	"	32. net	gistrer's Signe	ature							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** January Doris C. Leonard 9:50AM /Medical 4b. City, Town, or Location of Death 4e. Fecility Neme (If not institution, give street end number) 4c. County of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson if Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (Stata or Foreign Country) **Funeral** 1 □ M 2⊠ F Days Hours 92 Yrs. Director Aug. 16,1905 North Carolina 245-14-0831 Usuel Residance of Decedent r 28a-f show notified at 10e Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits Director 1 ☐ Yes 2 ☒ No Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 6 must be or thems 23a U.S.A. Funeral 2007 Dumont Road 21093 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yas 2₺ No Specify: by Specify: 3℃ Widowed 4 Divorced "natural". White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede complated) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 permit. Pages 1 and 2 should be filled Department of Health and Mental Hygi Important: If flein 27 is marked other 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) N. S. Crisp Clara Unknown 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Lutherville, Maryland 21093 Cal Stone/Son-in-Law 2007 Dumont Road 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Buriai 2 ☐ Cremetion 3 ☐ Removel from State Sardis Cemetery 1/28/98 Hudson, North Carolina 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerei Service Licensee 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the diseasa, or emplications the correct had death. Do not enter the mode of dying, such as cardiac or rasplratory arrast, shock, or haar failure. Lift only one ceuse or mich line. Approximate Intarval Between **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest and Due to (or esist consaquance of): Physician/Medical the Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 □ Yes 2 No 3 Probably 4 Unknown Malnutstran þ 24b. Wera autopsy findings available prior to completion of causa of death? 24e. Wes en eutopsy performed? Completed GONGRENE, EMBOLI 1 ☐ Yes 2 ☐ No certificata of Vital Attending Physician: Be 25. Wes cese referred to medical examiner? 26. Plece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Dev Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturet 5 Pending investigation s effer death.

Director: Aff 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Sulcide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours ef To the Funeral Di completely filled in Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es stated.

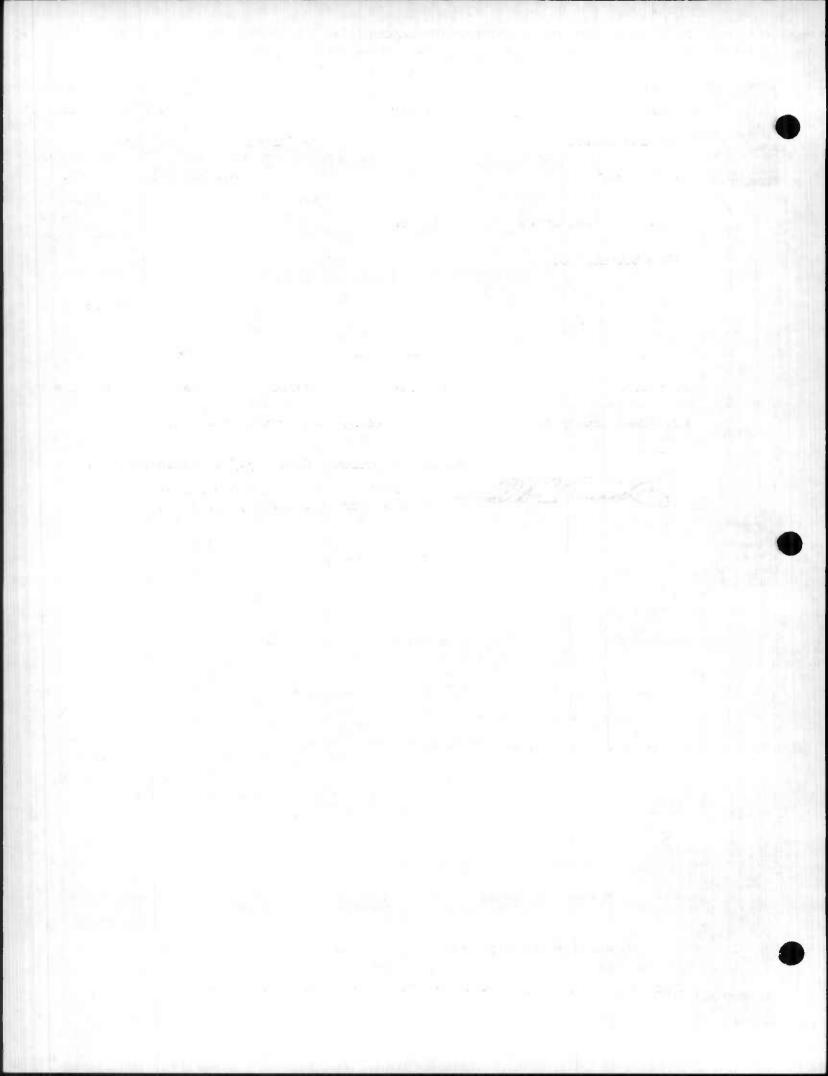
Madical Exampler: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end dua to the ceuse(s) and menner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) use of death (Item 23e) (Type, Print) HARFORD RD BALTIMORI-

Registrar



State of Maryland / Department of Health and Mental Hygiene Q

	-	1. Decedent's Nar	ma (First, Middle, L	ast)		Cei	rtificate of	Death	2. Data of D	Reg. No.		3. Time of Death
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land		10a. Stata	10b. County		10c. Cit	ty, Town or Lo	cation				1	Od. Inside City Limits
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28a-f	Director	10e. Street and No				Ital Coll	10f. Zip Coda			10g. Citizan of	What Cour	ntrv?
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within 72 hours effer death with the Maryland ene. than "natural", or thams 23a or 28a-f ahow ha Medical Evarriner must be notified at	Funeral		rriad 2 Marrled	1 ☐ Yes	21 No		Was Decedant of H		erto Rican, atc.)		ick, Whita,	
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ts DE E		19a. informant's N	Name/Relationship	(Type, Print)		19b. Mailir	ng Addrass (Straat	and Number or	Rural Routa Num	ber, City or Town	, Stata, Zip	Coda)
elth 27 I		Mr. Fran	k Lucas/s	son		1505	Berwick :	Rd. Ruxt	con, Md.	21204		
pemit. Pages 1 end 2 Department of Heelth e Important: If item 27 is any injury or other tra once.		20a. Mathod of Dis				Place of Dispo	sition (Nama of natory or other pla	ca)	Data	20c. Location	- City or To	own, Stata
Page ent c nt: If ry or			Cremation 3 5 Other (Speci		otata		Nationa		2/4/98	Arlingt	on T	7.3
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To the Hospital or Attending Phys within 24 hours effer death. To the Funeral Director: Affer this completely filled in by the funeral di	edical	29a. Cartifiar (Check only one)	1⊠ Certifying Pt 2 Medicat Exa	nyalcian: To tha t minar: On tha be and mann	sis of axamina	wledga, daath tion and/or Inv	occurred at tha tir rastigetion, in my o	ne, data and pla plnion, daath oc	ce, and dua to the curred at tha time	e cause(s) and m , data and place	annar as s , end dua to	tated. the ceuse(s)
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State of Maryland / Department of Health and Mental Hygiene Item: 10e Per FH Film G-755 1-28-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 03.83 PM **Physician** JAK9 CARY Catherine D. Lyons /Medical 4b. City. Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not Institution, give street end number) Examiner North Aryalel HOS RITUI
7 Age (In yrs. lest birthday)
Yrs. Burnie Glen Arunde If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Months Days 1□M 2√F 146-05-5210 90 Director Aug. 22,1907 New Jersey Usuel Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Severna Park Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or itams 23e or treumatic event, the Medical Examiner must be 427 Ferwood Drive 21146 U.S.A. FERNWOOD DRIVE Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Exec. Secretary Hercules Powder Co. 18. Mother's Neme (First, Middle, Maiden Sumame) 17, Fether's Neme (First, Middle, Last) Pages 1 end 2 should be f nent of Health end Mental I John Guilfoyle Mary Guilfovle 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) of Health 427 Fernwood Drive Severna Park, Maryland 21146 Michael J. Lyons Son 20b. Placa of Disposition (Name of cametery, crematory or other plece) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 0 New Calvary Cemetery Jan. 28, 1998 Sayreville, N.J. 21. Signature of Funerel Servica Licenses 22. Neme and Address of Fecility McCully-Polyniak Funeral Home 3204 Mountain Road Pasadena, Maryland on each line.

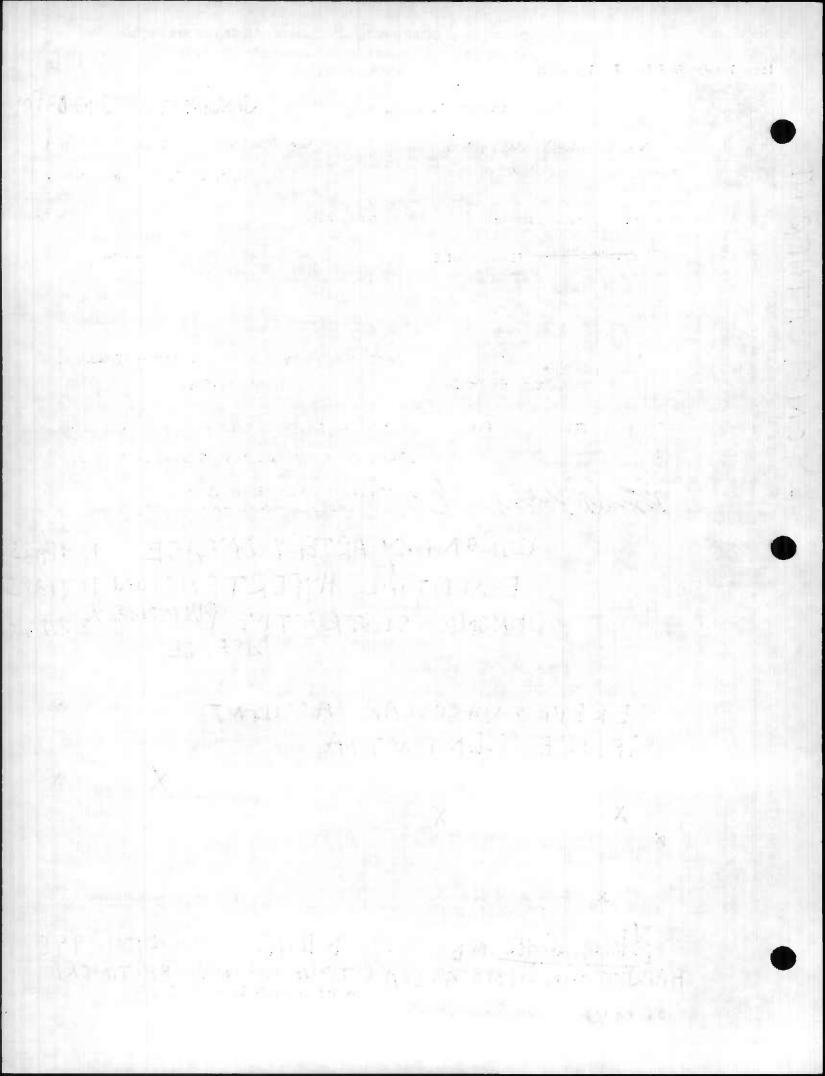
Maryland on each line. 21122 Approximate Intervel Between Onset end Deeth 23a. Pert1. Enter the diseese, or complications the shock, or heart failure. List only one cause **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Examiner ENSION Examiner physician end the burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting In deeth) Lest P.O. Box 68760 Physician/Medical ISEASE 980 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. CC Ti Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? has 1 ☐ Yes 2 No Division of Vital or Attending Physician: 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpetient 3 DOA 2 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigetion after deeti 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 24 hours a 29e. Certifier 🖎 Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner as stated. Medical completaly (Check only one) 2 Medical Examinar: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date and placa, and due to the cause(s) end menner stated. within 2 To the 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and tale of certifie JANUARY 24, 1998 15410-APIRITCH HIGHWAY, BALTIMORE

32 Registrar's Signature

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Registrar

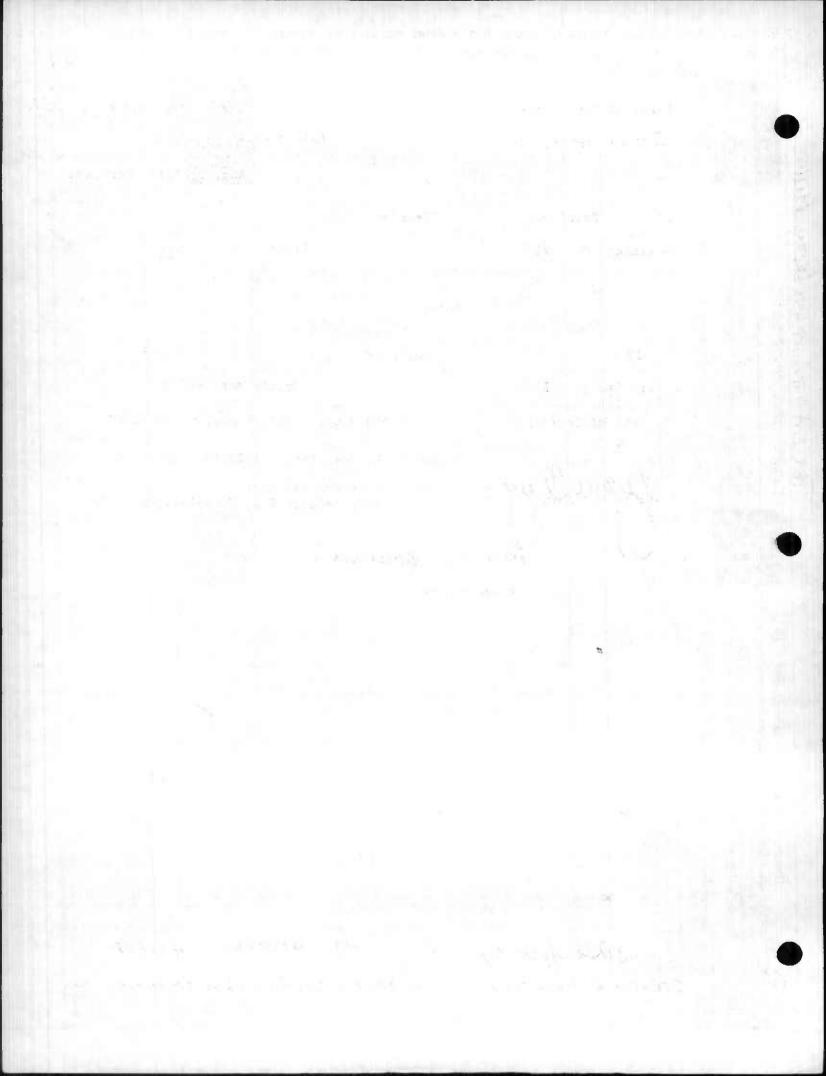
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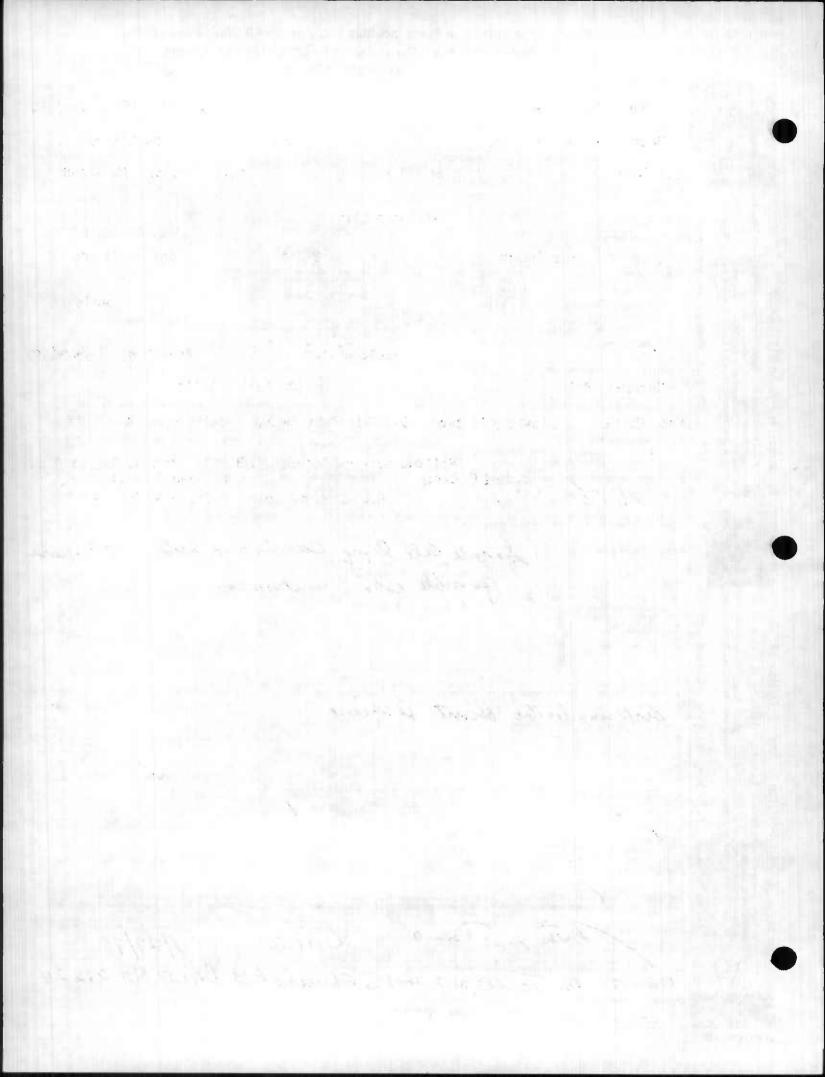
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xamin	er	4a. Facility Name (If			ber)			4b City, Town, or L			of Death	
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neral		5. Sociel Security Nu			'. Age (In yrs. le		If Under 1 Year Months Days		8. Date of Bir (Month, Da	th ly, Year)	9. Birthplace Country)	(State or For
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8	Director	10e. Street and Num	ern Ct.,	#101			10f. Zip Code	21093		10g. Citizen of V	What Country?	
THE STATE OF	Ta .	J IIIICE	III CL.,	1/101				21075		USA		
the Medical Examiner must be notified at	Funeral	11. Marital Status		12. Was Deced	lent Ever in U,S ces?	3. W	as Decedent of I	Hispanic Origin? (Sp ean, Mexican, Puerto	pecify Yes or No Ricen, etc.)	- 14. Rac	e - American inck, White, etc.	ndian,
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matica	10	Harry G	George M	iller				Myrtle	Mary S	Sefton		
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any injury or other		20a. Method of Dispo				ace of Disposi	ition (Neme of etory or other ple	ice)	Date	20c. Location -	City or Town,	State
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DHMH 16 Rev 6/95

Patient Known As: Leay Hiller



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) Month **Physician** 27 1998 5:15am January Mullin James Dennis /Medical 4a Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 6108 Ridgeview Avenue If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Sociel Security Number 7. Aga (In yrs. last birthday) If Undar 1 Yaer Birthptece (Stata or Foreign Country) **Funeral** Days Months Hours 100 M 2□ F 214-44-2303 Director 51 July 16, 1946 Maryland Usual Rasidance of Dacedant the Marylend 10c, City, Town or Location 10e Stata 10d. Insida City Limits 10b. County 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 X Yas 2 □ No Baltimore City Directo Maryland N/A 10g, Citizan of What Country? 10e. Street and Number 10f, Zip Coda 21206 United States 6108 Ridgeview Avenue Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indien, Btack, Whita, atc. flled within 72 hours efter 1 ☐ Navar Married 2 ☑ Married 1 Yas 2 No Spacify: Specify: þ 3 ☐ Widowad 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ant of Health end Mental Hyglena. nt: if item 27 is marked other than " Elementery/Secondary (0-12) College (1-4or 5+) Towing/Service Station Proprietor 11 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Irma Marie Kalus James Joseph Mullin 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 6108 Ridgeview Avenue Baltimore, MD Mrs. Fillippa L. Mullin / Wife other 1 Baltimore, 20b. Ptace of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 0 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramovel from Stata Depertment of Important: If 4 ☐ Donation 5 ☐ Othar (Specify) Hilltop Service Corp. 1/28/1998 Towson, Maryland 22. Nama and Addrass of Fecility 21. Signature of Funeral Service Licensea Michael E. Canapp Leonard J. Ruck, Inc. Baltimore, MD 21214 5305 Harford Road 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarvel Batwean Onsat end Death **Physician** /Medical tmmediata Causa (Final (ARDIAC disaasa or conditio resulting in death) Examiner Dua to (or as a consequance of): Examiner therosci physician and s the burial-trans Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or injury that initiated avants resulting in death) Last Dua to (or as a consaquance of): certificate be exec Hypertensia Box 68760 Physician/Medical Dua to (or as a consequance of): 89 use ö 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown signed t à 24b. Wara autopsy findings available prior to complation of ceusa of deeth? 24a. Wes en autopsy performed? Completed peen has paga 2 1 Yes 2 LAG 1 Tyes 2 No. certificata or Attending Physician: after death. Director: After this certific director, Be 25. Wes cesa refarred to medicel examiner? 26. Place of Deeth (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4□ Nursing Home 5 Phasidanca 6 □ Othar (Specify) P 1 Yas 2 No funerel 28a. Data of Injury (Month, Day Year) 28c. Injury st Work? 28d. Dascribe how Injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be datarmined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida Mospital of 24 hours a Funeral D 1 🖟 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 29a. Certifiar Medical completely 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. (Check only one) within 2 29b. Signature end title of certifier 29c. Licansa number 29d. Date signed (Morth, Day, Year)

HARPORD RUAD BARTIMURE Md

Registrar

State

30. Nama end address of paratra wife completed causa of death (Item 23a) (Type, Print)

8700

32, Registrar's Signetura

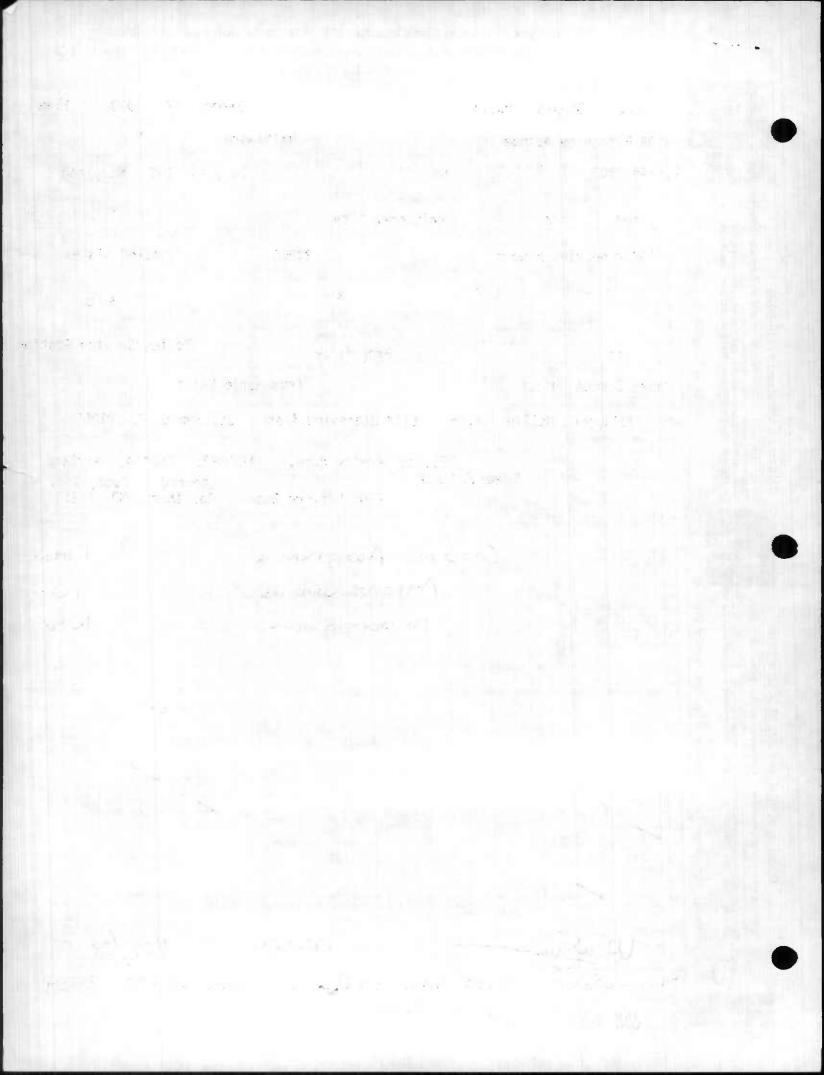
raia Davidson-Randall

MICHAEL SUREY

28 1998

31. Data filed (Month, Day, Year)

IAN



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Dafe of Death 1. Decedent's Name (First, Middle, Last) Month Day ALAR Salvatore Miraglia, Sr. January 27, 1998 J. 4c. County of Death 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 3001 Acton Road Parkville Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 → M 2 ☐ F 7. Age (In yrs. last birthday) Days Months Yrs. 78 June 22,1919 New York 216-16-2635 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3001 Acton Road 21234 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Edgewood Arsenal 12 Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Zanghi Miraglia Domenica Joseph 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) J. Miraglia, Jr. /Son 8501 Harford Road Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/30/98 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Leonard J. Ruck Funeral Home, Inc. 21. Signature of Funeral Service Licensee Timothy S. Harman 5305 Harford Road Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of degth? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy

Physician /Medical **Examiner**

physician end the buriel-trensit

Se

signed by the e

should

ils certificate hes t director, page 2 s

this funeral

within 24 hours efter death To the Funeral Director: A completely filled in by the f

The law requires that the death certificete be executed

Division of Vital Records, P.O.

or Attending Physician;

death.

Examiner

Physician/Medical

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Completed

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Certification:

Medical

Physician

/Medical

Examiner

Director

Funeral

by

Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Marylend Depertment of Heelth end Mantel Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expenses.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest

1 ☐ Yes 2 ☐ NO

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25.	Was case examiner?		d to medical
	1 Yes	2	6
27.	Menner of	Death	
	1 Netur	al	5 Pending

28a. Date of Injury (Month, Dey Year) Investigation 6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Thesidence 6 □Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

2 Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and fitle of certifier municiono. 29c. License number

29d. Date, signed (Month, Day, Year)

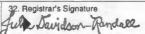
30. Nime and address of person who completed cause of death (Item 23a) (Type, Print)

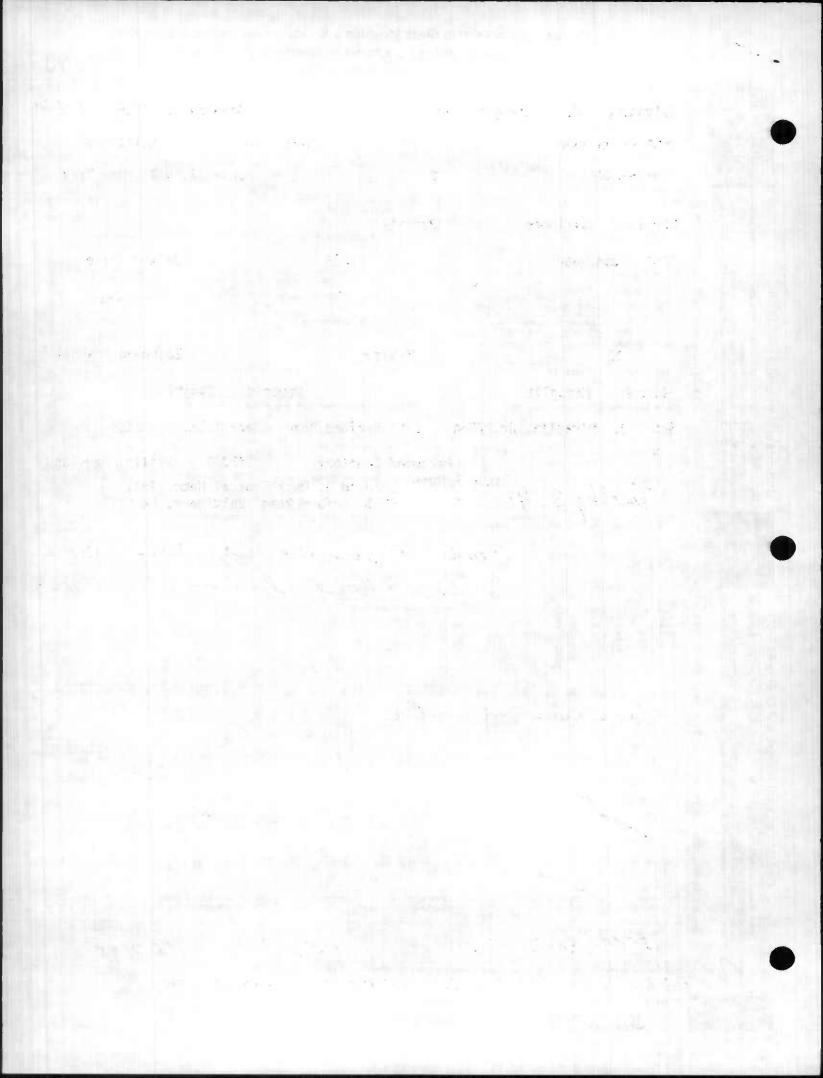
PATIZICIO 8903 Harford Road CiN

Balto, MD 21234

State Registrar 31. Dafe filed (Month, Day, Year)

28 1998





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-■ Item: 5 per F.H. G-756 2/10/98 reb Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month UDRA 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth LOWSON BALTIMORE MANOR HILL 5. Social Security Number 511 6. Sex 551-48-0734 10 If Under 1 Year Months Deys If Under 24 Hrs. 8. Dete of Birth
(Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) 1 M 2 F Dec. 2, 1910 Indiana Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Baltimore Towson 1 Yes 2000 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21286 101 Willow Ave United States 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritei Stetus Bleck, White, etc. 1 ☐ Yes 2X No If Yas, Give Yeer or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2X No Specify: Specify White **¾** Widowed 4 □ Divorced 16a, Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Sacondary (0-12) Collage (1-4or 5+) Homemaker Own home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) (Unknown) Wood Emma (Unknown) 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Weller / Daughter 101 Willow Ave., Towson, MD 21286 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlei 2 Cremation 3 ☐ Removel from State 1/28/98 Green Mount Crematory Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD enter the mode of dying, such as cerdiac or respiratory errest, 21286 23a. Pert1. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as ce shock, or haart failure. List only one cause on each line. Immediete Ceuse (Final disease or condition resulting in death) C'erebrouascular Accident serebrovascular Due to (or es e consequence of) 23b. Did tobecco use contribute to the cause of death?

Physician /Medical Examiner

and

Physician

/Medical

Examiner

Director

Funeral

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Completed

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10a. Stete

Funeral

Director

Show

Item 27 is marked other than "natural", or flems 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed wi Department of Health and Mental Hygien, Important: If Item 27 is marked other thi any filury or other traumatic event, the once.

filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0020

with the Maryland

death v

Examiner Sequentially list conditions, if eny, leeding to immadiata ceuse. Enter Underlying Ceuse (Diseese or injury Physician/Medical thet initiated events rasulting in death) Lest

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of daath? 24e. Wes an autopsy performed? 1 Yes 1 ☐ Yas 2 ☐ No 25. Wes cese referred to medical examinar? 26. Piece of Deeth (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Daeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Panding Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide to Certifying Physician: To the best of my knowledga, death occurred et tha tima, data end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, daeth occurred at tha tima, data and plece, end due to the ceusa(s) end menner stated. 29a. Cartifier (Check only one) 29d, Date signed (Month, Dey, Year) 29c. License number

es the buriel-trensit Box 68760. ettending physician certificate be esn P.O. signed by the Records. þ Completed peen has pege 2 certificate Division of Vital • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific Be 2 Certification: within 2 To the

D-17041

30. Name end addrass of person who complated cause of deeth (Item 23a) (Type, Print) eaver Road Ste 38 Lutyerville my

31. Dete filed (Month, Day, Year)

28 1998

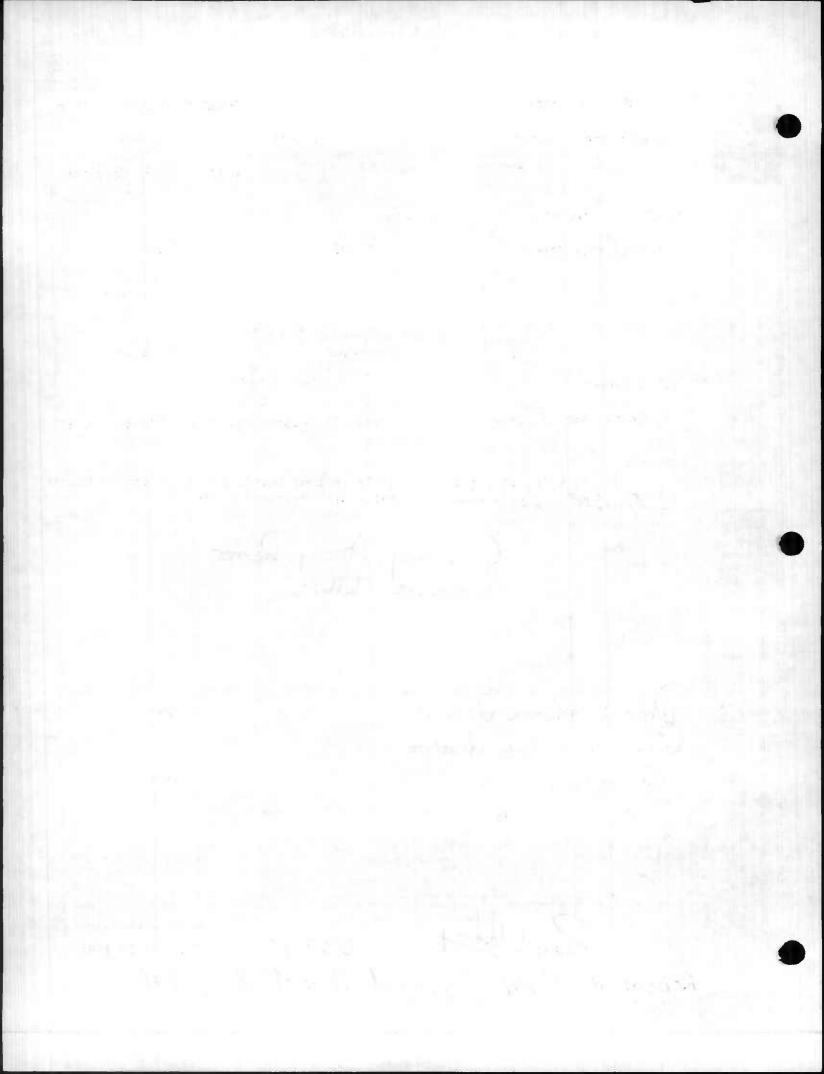
32. Registrer's Signeture Fisher Davidson-Randell

State Registrar

and the first th

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	ian	Decedent's Name (First, Middle, L					Date of Death Month		Voor	3. Time of Deat
/Medi	cal	Anna Bella Mag				4.05	JANUARY			945am
Examii	ner	4a. Facility Name (If not institution, gi Sacred Heart Hos)		4b. City, Town, or Lo Cumberla		4c. County		
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23a or 28	al Director	10e. Street and Number 608 Frederick S	treet		10f. Zip Coda 21502			g. Citizen of V	Vhat Country	/?
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PEE	-	19a. Informent's Name/Relationship	(Type, Print)	19	b. Mailing Address (Stree	t and Number or Rure	al Route Number,	City or Town,	State, Zip C	ode)
E 01 -		Charlotte Fishe	r/sister	9	27 Ampere P	lace,Lake	St. Loui	ls, Mis	souri	63367
nent of Heelt int: If item 2 iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [4∑ Donation 5 ☐ Othar (Space		20b. Placa	of Disposition (Name of ery, crematory or other pla			0c. Location -		
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State of Maryland / Department of Health and Mental Hygiene

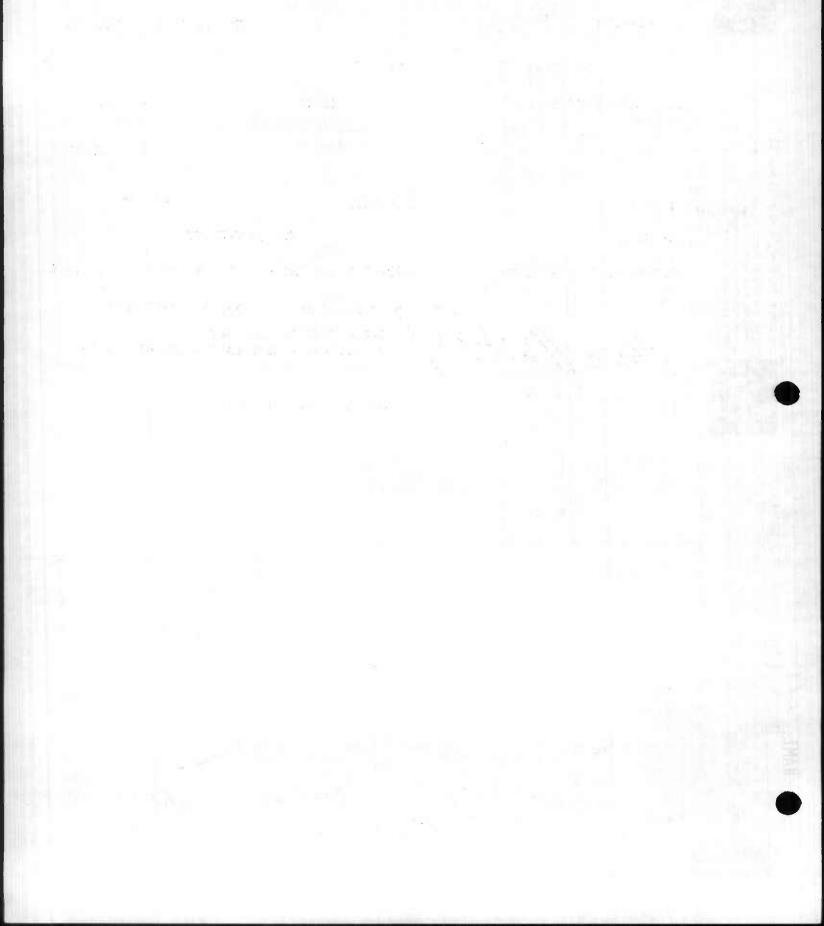
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** MILES CLYDE HUTCHINS JANUARY 20, 1998 04:35 /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner BALTIMORE BALTIMORR AGNES HUS PITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 12 M 2 □ F Yrs 215-01-6288 94 Director 12,1903 DELAWARE Usual Residence of Decedent with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinal must be notified all 1 Yes 2 No BALTIMORE Director BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21227 1228 LINDEN AVENUE Funeral death 12. Was Decadent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after tant of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or ite 1 Never Married 2 Narried 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. à WHITE 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) PRIVATE 12TH GRADE MACHINIST 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) EVALYN BENNETT IRA MILES 2 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 12494 BARNARD WAY - WEST FRIENDSHIP, MD. 21794 DOROTHY RICH (DAUGHTER) other 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o t Burial 2 ☐ Cremetion 3 ☐ Removal from State 1/22/98 4 ☐ Donation 5 ☐ Other (Specify) LOUDON PARK CEMETERY BALTIMORE 21. Signature of Funeral Service License 22. Name and Address of Facility
HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229 Enter the disease, or complications that caused the design. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final MYUCARDIM INFARCTION diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner SEIZURES physician and is the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of) 88 signed by the ettanding d be detached for use as Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probabty 4 ☐ Onknown þ 24b. Were autopsy findings evallable prior to 24a. Wes en eutopsy Completed peen completion of cause of deeth? hes 1 Yes 22 No 1 ☐ Yes 2 ☐ No certificate funeral director Be 25. Was case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes a No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient → DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Naturel deeth. 1 Yes 2 No Hospital or Attendi 24 hours eftar deeth. Funeral Director: A 2 Accident 6 Could not be determined To the Hospital or Atterwithin 24 hours efter der To the Funeral Director completely filled in by the 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29a, Certifier Medical 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) D0051865 8 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BALTIMORE, MD ST CHARLES CURTIS AGNES HOSPITAL 31. Date filed (Month, Dey, Year) 32. Registrar's Signature Idia Tavidson-Randall State Registrar JAN 28 1998

DHMH 16 Rev 6/95

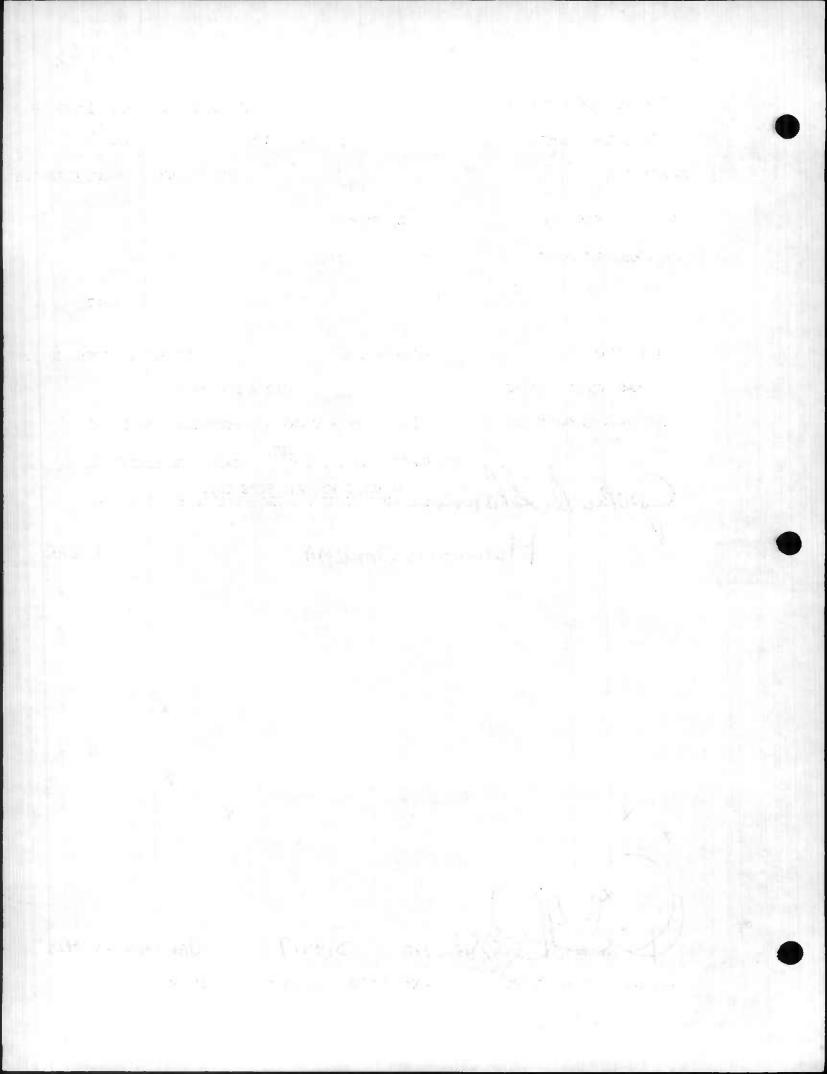
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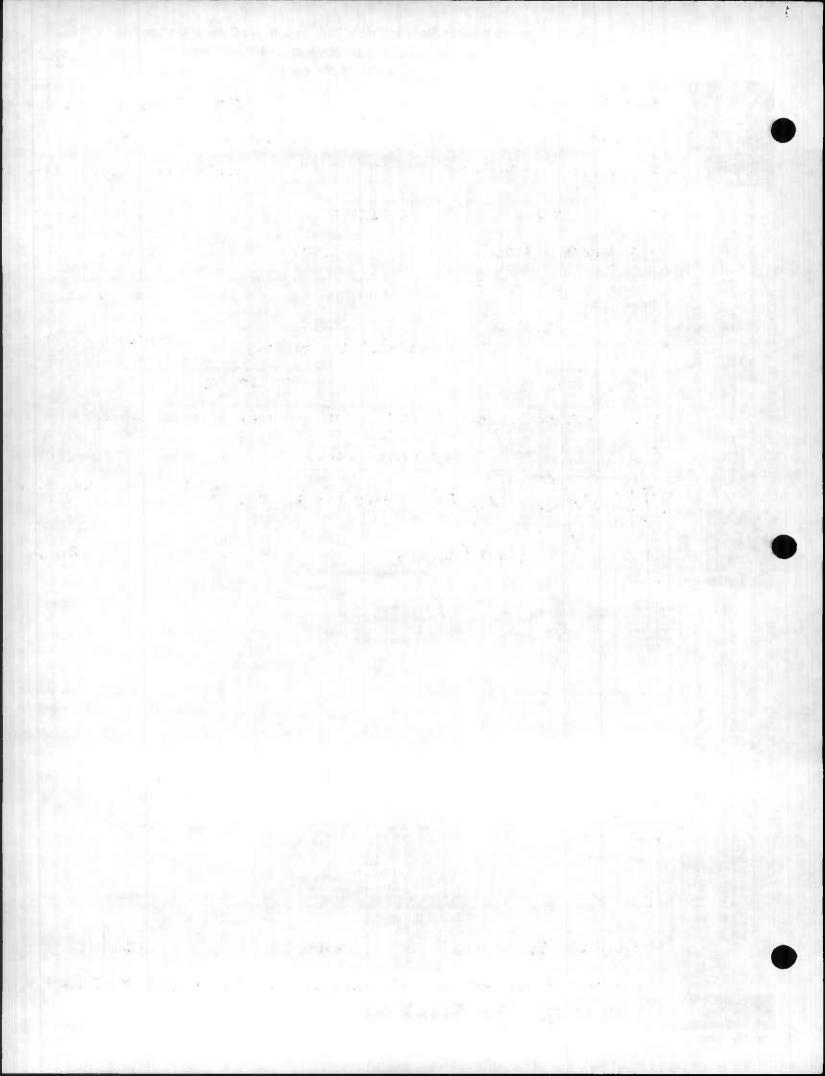
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Lest) 2. Dete of Deeth **Physician** Month WILLIAM MORRIS McFALLS **JANUARY** 21, 1998 12:07 AM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2798 RACHELE COURT MANCHESTER CARROLL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) **Funeral** M 2□ F Months Days Hours Yrs. Director 68 212-26-4275 JUNE 16,1929 NORTH CAROLINA Usual Residence of Decedent with the Marylend 10a Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or Items 23s or 28a-f show traumatic event, the Madical Examinat must be notified at 10d. Inside City Limits 1 Yas 2 XNo Directo CARROLL MANCHESTER 10e. Street end Number 10f, Zip Code 10g. Citizan of Whet Country? 2798 RACHELE COURT U.S.A. death 21102 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) should be filed within 72 hours efter ond Mental Hyglene. marked other than "natural", or lier 1 XYes 2 No If Yes, Give Yeer or Dates: 1 Navar Married 21X Married Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: by WW II 3 ☐ Widowed 4 ☐ Divorced WHITE 16e. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) 8TH GRADE STEELWORKER BETHLEHEM STEEL CORP. Depertment of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other there any Injury or other there. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnema) THOMAS LOVIS McFALLS P MARY ANN MORRIS 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Routa Number, City or Town, Stete, Zip Coda) BEVERLEY McFALLS (WIFE) 2798 RACHELE COURT - MANCHESTER, MD. 21102 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) CEM. GREENMOUNT U.M. CHURCH 1/24/98 HAMPSTEAD, MD of Funeral Service Licensee 22. Name end Address of Fecility HUBBARD FUNERAL HOME INC Kanner 4107 WILKENS AVENUE-BALTIMORE, MD 21229 Enter the diseasa, or compfications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, or haart failure. List only one ceuse on aech lina. Approximete Intervel Betw **Physician** /Medical Immediate Ceusa (Final YEAR disease or condition rasulting in daath) Examiner Due to (or as e consequence of) Examiner buriel-transit Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury thet initiated events resulting in daath) Lest and Due to (or as e consequence of): physician s the buriel Box 68760, 8 Physician/Medical Due to (or es e consequence of) 88 P.O. Part II. Other eignificent conditions contributing to deeth but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings evaileble prior to completion of ceuse of deeth? should 24a. Was en eutopsy performed? Completed page 2 No 1 🗆 Yas certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) exeminar? 1 ☐ Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 2 funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? 5 Pending Naturel 1 ☐ Yes 2 ☐ No 2 Acciden filled in by the 6 Could not be 3 🗆 Si 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide To the Hospital within 24 hours e To the Funeral D en: To the best of my knowledge, deeth occurred et the tima, deta end plece, end dua to the causa(s) end menner as steted.

er: On the bests of examinetion end/or investigation, in my opinion, daeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted. X Cartifying PM Certifler Medical 29c. License number 29d. Date signed (Month, Dey, Yeer) ANUARY 23, 1998 0 1/ 30. Nema end eddress of person who completed ca of daath (Item 23a) (Type, Print) DR. DIANA H. GRIFFITHS - 900 CATON AVENUE - BALTIMORE, MD 21229 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State relia Devidson-Handelle 28 1998 JAN Registrar



State of Maryland / Department of Health and Mental Hygiene 8 02055

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month John Peterlin /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Manland Universite Raltimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Months Deys Hours Min. (Month, Day, Year) South Carolina 9. Birthplace (Stere or rolling) Country) South Carolina 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 65 Yrs. 1 M 2□ F 247-46-6596 Director Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic evant, the Medical Examiner must be notified at BALTIHORE CITY 1 Yes 2 No Director NLA MARYLAND 10e. Street end Number 10g. Citizen of Whet Country? 1615 KIGGS AVENUE USA. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 No 6 11-53 If Yes, Give Yeer or Detes: 4 - 28-55 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than "natural", or Itam injury or other traumath. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No p Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) LUMBER COMPANY 10 +H GRADE TRUCK 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) ROBINSON SONNY FRANCES 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) BEATRICE PETERKIN (SISTER) 16 15 RIGGS AVE. BALTIHORE, MD. 21217 ca of Disposition (Neme of Dete 20c. Location - City or Town, Stete 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 01-26-98 OWINGS, MILLS MO. GARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217 21. Signature of Funeral Service Licenses 23a. Pert 1. Enter the disease, or complications that caused to leeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between **Physician** /Medical Immediate Ceuse (Finel Kespirator disease or condition resulting in death) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Due to (or as e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown þ 24b. Were eutopsy findings eveilebte prior to Completed 24e. Wes en eutopsy performed? completion of cause of deeth? 1 Yes Be 25. Wes cese referred to medical 26. Piece of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 Yes 2□ No Inpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 PNaturat 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Box 68760, P.O. I Records, Division of Vital

slcian and burial-transit attanding physician for use es the buria certificate has After this in by tha f

death with the Marylend

Baltimore, Maryland 21215-0020

Items 23a

of a standing Pettar death.

Director: After t with the Hospital with the Hours of Today Funara Completely filled

Registrar

29b. Signeture end title of certifier

4 Homicide

(Check only

31. Date filed (Month, Day, Year) JAN 28 1998

29a. Certifier

edical

MD

29c. License number 10350

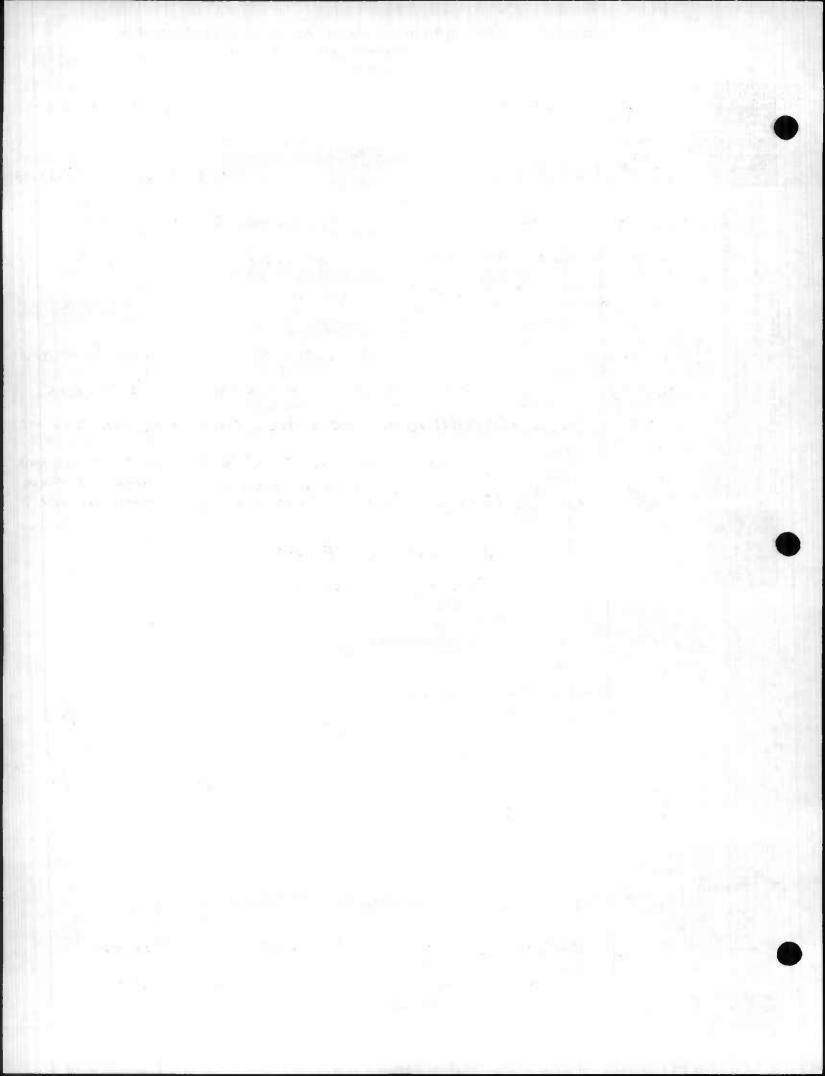
1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the bests of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end manner steted. 29d. Date signed (Month, Dey, Yeer)

Baltimore, maryland

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) south

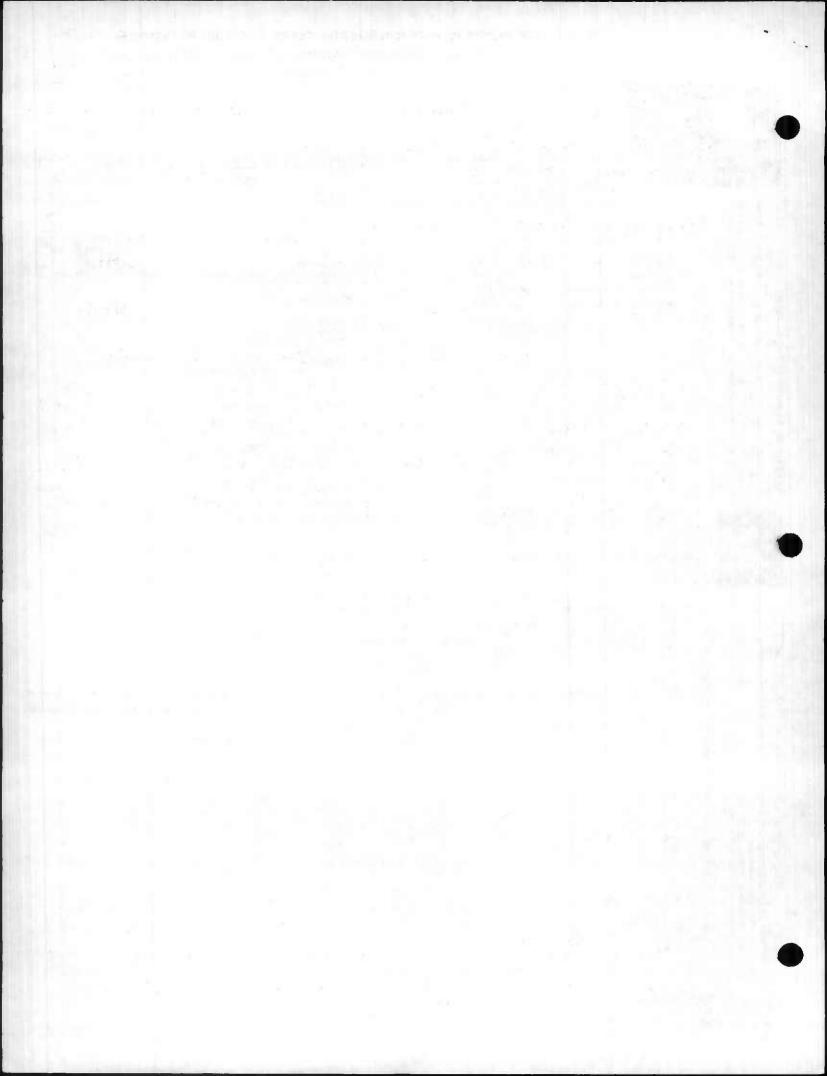
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39 Registra's Signature Handall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1)

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State of Maryland / Department of Health and Mental Hygiene Q 02058

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Ì	Physician /Medical	1. Decedent's Name		Ronald			Pl	owman			2. Dete of De Month JANUA	Day	Year 998	3. Time 0		
	Examiner	4e Facility Name (f.	f not institution, giv	e street and number)			4	b. City, Tov	vn, or Loc	ation of Deat	-	of Deeth	, , , ,		
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Funeral Director		5. Social Security N 262-59-97 Usual Residence of	708	M 2□F	ge (In yrs. la	1 Yrs.	Months		Hours	Min.	8. Date of Bir (Month, De)ctober	ny, Year) 9,1966	9. Birthp Court	olace (State otry) cylanc		
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	or 28.	10e. Street and Nur						ip Code				10g. Citizen of V	What Cour	itry?		
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020	urs effer deeth with the Ma el', or items 23s or 28s-1 s Examiner must be notified by Funeral Director	11. Marital Status 1 Never Merri 3 Widowed	ed 2 Married 4 Divorced	Armed Forces 1 Yes 2 1 If Yes, Give	12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Yeer or Dates:			13. Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexicen, Puerto F				Rican, etc.) Bieck,			- American Indien, , White, etc. White	
Baltimore, Maryland 21215-0020	within 72 ho ane. Ithan "neturn Medical	(Spec	ducation ade com <i>pleted)</i> College (1-4or	cation a completed) College (1-4or 5+)			ual Occupe ork done d use retired	during most	of workin	king		struction				
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Balt	permit. Pa Departmen Important: any Injury ance.	21 Signature of Facility Stallings Funer 3111 Mountain Road, Pasadena, 1														
	Physician	23a. Part1. Enter the shock, or hear	23a Part Enter the disease, or complications that coulsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about, or hour failure. List only one cause on each line. Approximate interval Between Onset and Death											etween		
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Stab-wound of abdomin Due to (or es e consequence of):														
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ouo	Attending Physician: or deeth. ector: After this certific by the funeral director, lification: To Be (27. Menner of Death 1 □Natural	5 Pending investigatio	(Month, D	28a. Date of injury (Month, Day Year) 1 → 2 U O S				yat k? Yes 2 ဩ!	28d. Describe how injury occurred to Subject Stables 5				Lwith	ann.	
Division	tal or Attending Purs efter deeth. Tal Director: After tiled in by the funeral Certification:	2 ☐ Accident 3 ☑ Suicide 4 ☐ Homicide	a Ed Could not be					ne, farm, street, factory, office				28f. Location (Street and Number or Rorel Route Number, City or Town, State) 77 88 Outing Avenue				
	Se les O				HOME					1	reade	na, Anne	Arun	del Co		

DONALD G. WRIGHT MD 31. Date filed (Month, Day, Year) State Registrar JAN 28 1998

29b. Signeture end title of certifier

29a. Certifier

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature whie Davidson-Randalls

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated.

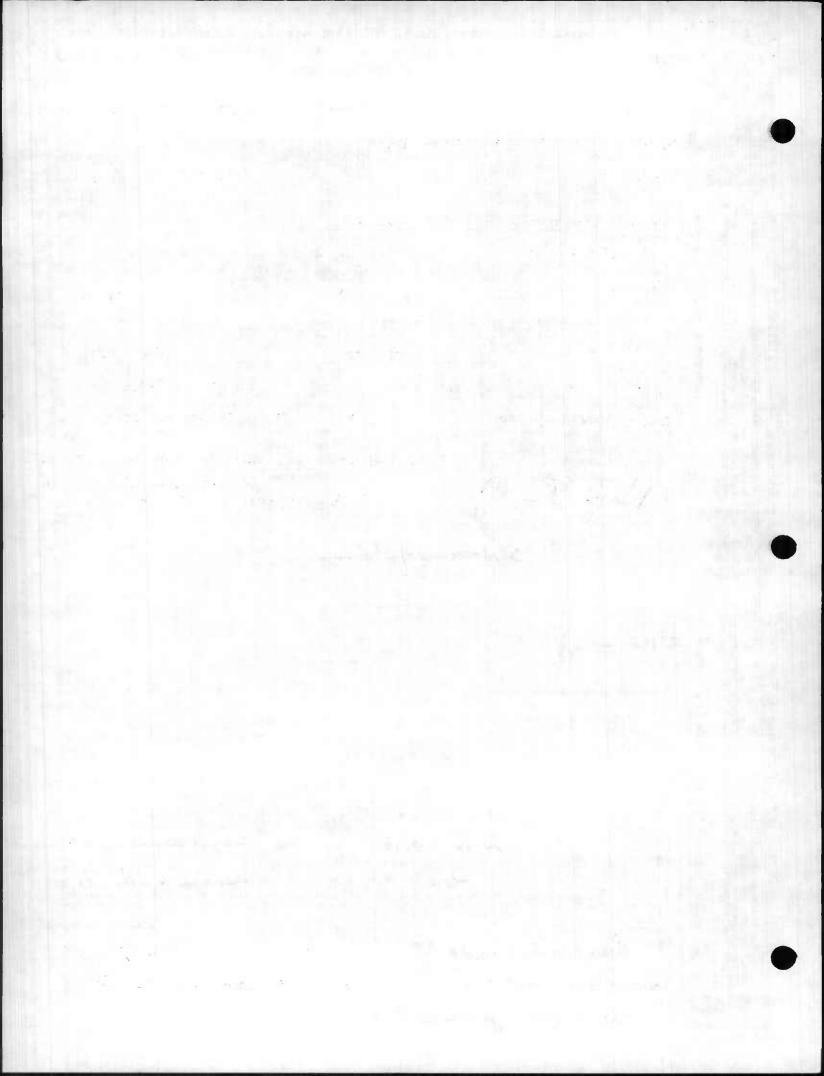
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JANUARY 25, 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Deeth **Physician** Month martha Perry 3.10 Km 01 /Medical 4a. Fecility Nema (If not institution, give streat end number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** Baltimore MD Nommanne A ff Undar 1 Yaar | if Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (Steta or Foraign Country) **Funeral** 1 M 200 250-20-7475 84 Yrs. Director South CAROLINIA Usual Rasidance of Dacadant 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Md. BALTIMORE Director event, the Medical Examiner must be notified 10e. Street and Number 10g. Citizan of What Country? 1802 5 A AroliNE Funeral 12. Was Dacadant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Datas: 14. Race - Amarican Indian, Black, Whita, atc. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Maritel Status 1 Navar Marriad 2 Married 1 Yes 2 No þ 3 Widowed 4 □ Divorced BLACK Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Home MAKER 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Brown MAKThA 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1802 N CAPOLINE St. 13Alto. ROSA WAShington-Sister 20a. Method of Disposition 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Steta Data 1 Burial 2 Cramation 3 Removal from State 1/30/98 Mt. CALVERY Com. 4 □ Donation 5 □ Other (Spacify) 22. Name and Address of Facility Broad way Balto. md. 21213 21. Signatura of Funaral Sarvice Licensee Miller P.C. Funeral Home + Services 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart fallure. List only one ceuse on each line. Approximate Intervel Between Physician with lives I long melas ta sz /Medical Immediata Ceuse (Final Carcinoma disaasa or condition resulting In death) Examiner Due to (or as a consequence of) Sequantially list conditions, if any, leading to immediata ceusa. Enter Underlying Cause (Disaasa or Injury that Initieted avants resulting in death) Last Physician/Medicai Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown λq 24b. Wera autopsy findings eveileble prior to complation of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 20 No 25. Wes cesa rafarrad to medical examinar? Be 26. Placa of Daath (Check only one) Hospital: 1 ☐ inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 1 Yas 2 No Othar: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) Certification: To 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 27. Manner of Death 28d. Dascribe how Injury occurred 28c. Injury et Work? 5 Panding invastigation 1 HNatural 1 ☐ Yas 2 ☐ No 2 Accident

buriel-transit and Box 68760, ettending physician P.O. Division of Vital Records, certificate or Attending Physician: After deeth. To the Hospital or Attendi within 24 hours efter deeth. To the Funeral Director: A completely filled in by the fi

Maryland 21215-0020

altimore,

filed within 7 Hygiene.

permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than

Pages 1

3 Suicida

6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Spacify) 4 Homicida

29a. Cartifiar 1 Certifying Physician: To the bast of my knowledge, daath occurred at the time, deta and place, and dua to tha causa(s) end menner es stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29d. Data signed (Month, Dey, Yaar)

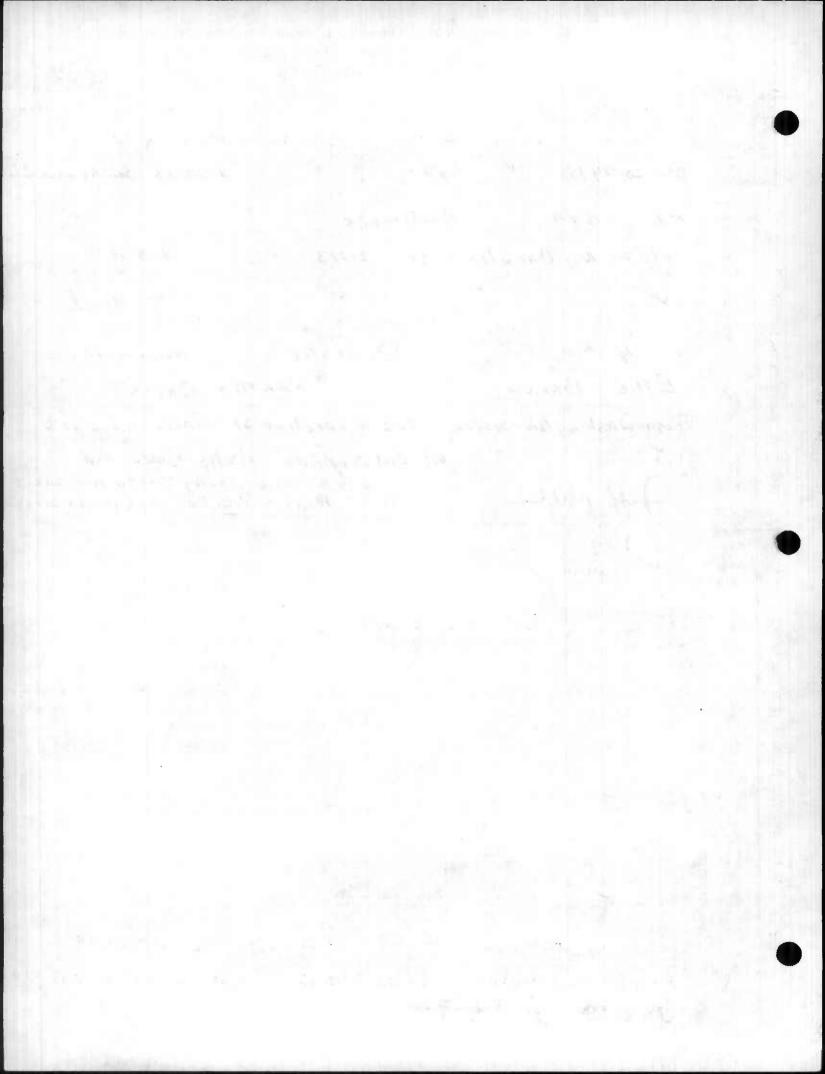
D31464

30. Nama and addrass of person who completed cause of death (Itam 23a) (Typa, Print) , 821 N. ENTAW ST SINTE 308, Balt. MD 2126 HASHMI

31. Data filed (Month, Day, Year) 28 1998

State Registrar

Medical



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth Month Dey January 15 Allen **Physician** 5:47 PM 1998 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Q **Examiner** BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) Yrs. If Undar 1 Yaar If Under 24 Hrs. 6 Sex **Funeral** 100 M 2□ F Months Deys Hours 248-18-2980 Usuel Residence of Decedent Director 1-1917 Grentalls, S.C. filed within 72 hours efter death with the Maryland 10a. State 10b County 10c. City, Town or Location Od. Inside City Limits 28a-f show other traumatic evant, the Medical Examiner must be notified at 1 Yas 2 No Director n Ary And 10e. Street end Number Allimore 10f. Zip Code 10g. Citizan of What Country? ò itams 23a Completed by Funeral 21205 12. Was Decadem Evar in U,S.
Armed Forces
1 Des 2 □ No
If Yes, Give
Year or Dates: W W T 13. Wes Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - Amarican Indian Black, White exc 1 ☐ Never Married 2 ☐ Married 1□ Yes 2E No ò Specify: 3 Widowed 4 □ Divorced "natural", MERICAN 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use refired) 15. Decedent's Education 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiana. Important: If Item 27 is marked other than any Injury or other traumatic evant. Elementary/Secondary (0-12) College (1-4or 5+) Welder Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 Eri 19e. Informent's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rurel Route-Number, City or Town, Steta, Zip Code) 200. Place of Disposition (Name of cemetery, cremetory or other p BAlto, md 20e. Method of Disposition 20c. Location - City or Town, Steta 1 D Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Enfor the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errespondent adjusts. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** acute myocardial infanction /Medical Immadiate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner chemic or Attanding Physician: The law requires that the deeth certificete be executed Sequentially list conditions, if eny, leading to immediata ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, ettending physician Physician/Medical the Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? sete has been signed by page 2 should be detact 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Be Completed 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? within 24 hours after death.

To the Funeral Diractor: After this certificate has 21 NO 1 ☐ Yes 2 No 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12 Yes 2□ No 1 Inpatient 2 ER/Outpetient 3□ DOA in by the funerel 27. Manner of Deeth 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Neturel 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homleide Hospital 29a. Certifier Certifying Phyelclen: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end manner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and menner steted. Medical tha

29c. License number

Hospital

000

29d. Date signed (Month, Dey, Year)

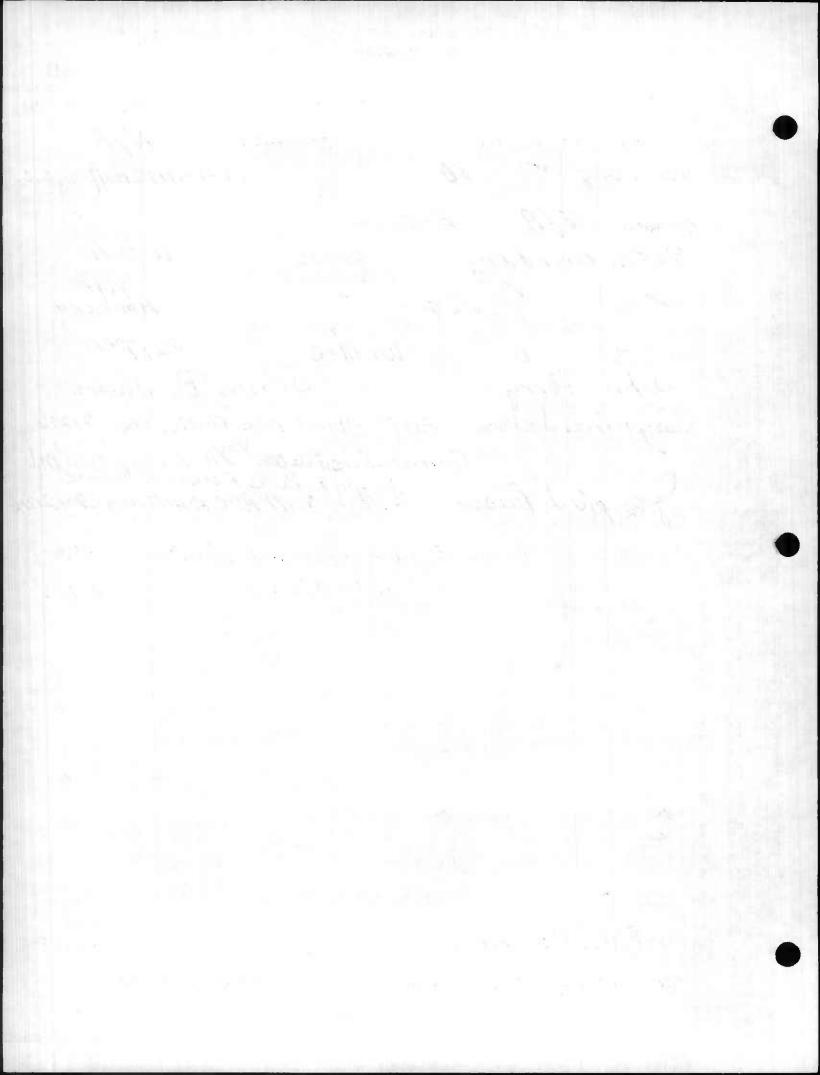
State Registra

29b. Signeture and title of cartifier

Patricia Chang

30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

MD Johns Hopkins



State of Maryland / Department of Health and Mental Hygiene S

ROBERT POWELL Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** Robert Gene Powell Jr. 26, 1998 JAN. 6:00 AM /Medical 4a Fecility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner U.S. ROUTE#70 CLEARSPRING WASHINGTON If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Sociel Security Number 7. Aga (In vrs. last birthday) Birthplaca (State or Foraign Country) **Funeral** 1X M 2□ F Yrs 233-17-3499 23 Director July 24 1974 MD Usual Rasidance of Dacedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d, Insida City Limits 7 is marked other than "natural", or flems 23s or 28s-f show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2X No Director Allegany Hancock 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 32 W. Main Street 21750 USA 2 should be filled within 72 hours after death and Mental thygiene.
Is marked other than "netural", or flems 23. Funeral 12. Wes Decadant Ever in U,S. Armed Forcas? 1 ☐ Yas 2∑ No Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 X Navar Marriad 2 Married Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highast grada complated) Elemantary/Secondary (0-12) Collega (1-4or 5+) Poly - Tech Carpenter 18. Mothar's Nama (First, Middle, Maiden Surname) 17. Fathar's Neme (First, Middle, Last) Be Robert Gene Powell Sr. Arlene Barber 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 end 2 st Department of Heaith and Important: If item 27 is n /mother Arlene M. King 2942 Sollers Point Rd other 1 Baltimore, MD 21222 altimore, 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data Jan 31 1 XBurial 2 Cremation 3 Removal from Stata 0 any injury o 4 Donation 5 Othar (Specify) 1998 Dulaney Valley Mem. Timonium, MD 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Fecility Connelly Funeral Home of Dundalk more 7110 Sollers Point Rd 23a. Part1. Enter the disease, or complications that caused the draftin shock, or heart fail ruy. List only one cause on each line. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, Approximata Intervel Between Onsat and Death Physician Immediate Causa (Final disaasa or condition rasulting in daath) /Medical Injuries Examiner Dua to (of as a consequence of): Examiner certificete be executed physician and s the buriel-trans Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequenca of) Box 68760 Physician/Medical Dua to (or as a consaquance of) 80 use for 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. the signed by t 1 Yss 2 No 3 Probably 47 Unknown b Division of Vital Records. 24b. Wara autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy performed? Completed page 2 s hes 18 € 2 No certificate 25. Was casa rafarred to madical axaminar? Be 26. Placa of Daath (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) ROADWAY XX Yas 2□ No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Dascribe how injury occurred uneral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? Certification: After motor vehicle acciden 1 Natural 5 Panding 1 Yas 2 -No invastigation 534-17M 2 Paccident 1-26-98 6 Could not be datarminad 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) ______#70 28a. Place of Injury - At homa, farm, straat, factory, offica building, afc. (Spacify) 4 - Homicida Street Washington Co Med

ital of Attending P within 2 To the To the

(Check only one)

29a. Cartifiai

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the dause(s) and mannar as stated.

2XDMadical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signatura and titla of cartifian

29c. License number O.C.M.E 29d. Data signad (Month, Day, Year) JAN. 27, 1998

30. Nama end eddress of persognation complated causa of daath (Item 23a) (Type, Print)

Demis mo

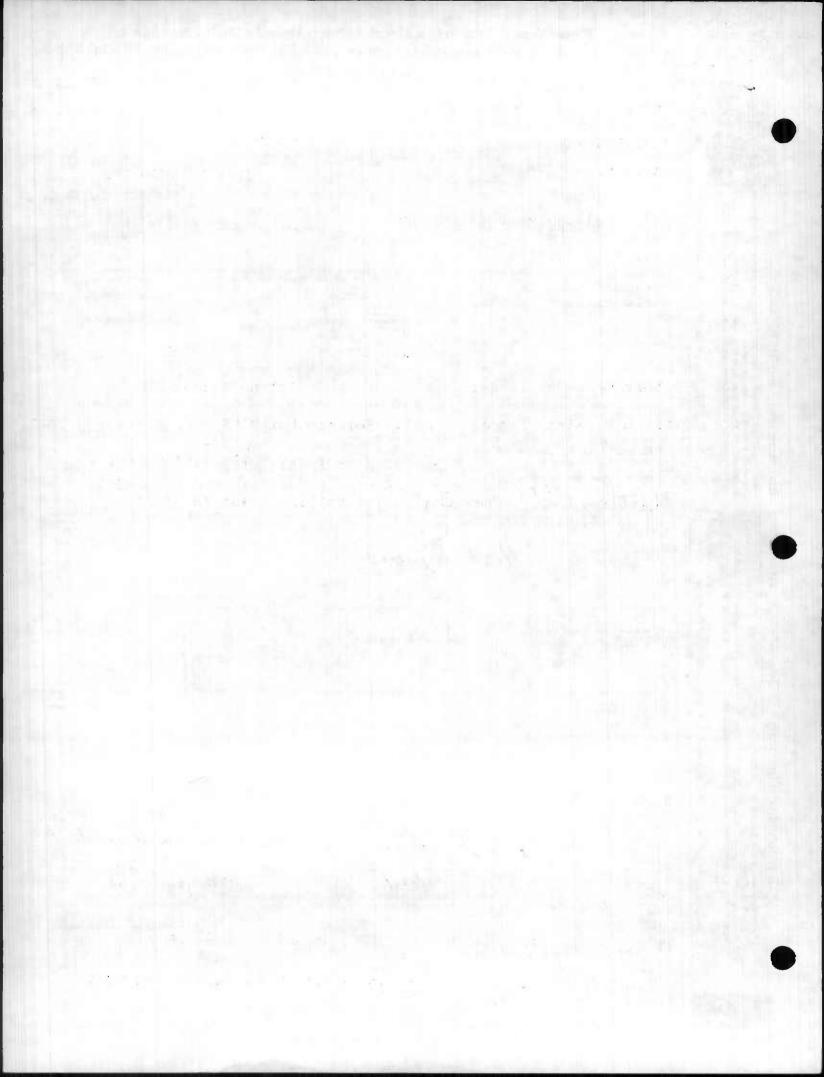
111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medical

31. Data filad (Month, Day, Yaar) 32. Registrar's Signature la Barden JAN 28 1998

8



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month **Physician** OLGA JANUARY 27, 1998 8:30 A.N /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ZISAS 0 ALUZIC owsor If Undar 1 Yaar If Undar 24 Hrs. 8. Dete of Birth Hours Min. Month, Dey, 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Aga (In yrs. lest birthdey) Funerai 1 M 25 F Months 95 Yrs. 20EH BG 416 Director Usual Residence of Decedent the Marylend 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 250 No Director BALTIMORZ MARYLAM Joswol 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 6 permit. Peges 1 and 2 should be filed within 72 hours efter deeth a Department of Health and Mentel Hygiene. Important: If Itam 27 is marked other than "natural", or itams 23-sary injury or other traumatic event, the state of the permits of the p A.2. 2300 (CLARRY RELLA KOA 21204 Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 200 No If Yes, Give Yaar or Dates: 14. Race - American Indien, Bleck, White, atc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Naver Married 2 Married 1 ☐ Yas Z No Specify: Completed by ₩ Widowed 4 Divorcad ETIKW Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest greda complated) 16b. Kind of Businass/Industry Elamentery/Secondary (0-12) College (1-4or 5+) SALES 127RS. TUZRKES 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Meidan Surname) Be KAHLIR AK9220L 0 HYRONIMUS DVORAK 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3,1093 HERVILL MARYLAND ROAD ROBERT W. JOSZIMAL 00P 20b. Placa of Disposition (Neme of cametary, cremetory or other pleca) 20a. Method of Disposition JAN.30 20c. Location - City or Town, State Buriel 2 ☐ Crametion 3 ☐ Removal from State HOLY ERASS GENELERY 1998 4 ☐ Donetion 5 ☐ Other (Specify) GLEN BURNIZ MARYLAD 21. Signa we of Funeral Service L 22. Name end Addrass of Facility EVANS CHARLOFEHINES 2325 YORK ROPO TIME 21103 Timprium PARYLAND VEN. 23a. Pert1. Enter the disease, or complication: hat caused the deeth. Do not antar tha mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Betwe Onset end Death Physician /Medical Immediata Cause (Finel disease or condition rasulting in daeth) **Examiner** Due to (or es e consequance of): Examiner I or Attending Physician: The lew requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and attending physician and for use as the bunal-trensit Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disees or injury that initieted events resulting In death) Last Due to (or es e consequance of): Physician/Medicai Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yas > No 3 Probably 4 Unknown THOKE þ Completed 24b. Ware autopsy findings evellable prior to 24a. Wes en eutopsy performed? completion of causa of death? this certificate has 1 ☐ Yes 250 No 1 ☐ Yes 2 ☐ No Be 25. Wes casa referred to medical 26. Placa of Daath (Check only one) Other: 5 Nursing Home 5 Residenca 6 □Other (Specify) P 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of

Box 68760, P.O. Records, Division of Vital

> State Registrar

filled In by the

Medicai

To the Hospital o within 24 hours af To the Funeral D completely filled I

29b. Signetura and titla of cartifier

1 Neturel

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

5 Pending

investigation

6 Could not be determined

29c. License number

TSC Certifying Physician: To the bast of my knowledge, daeth occurred at the time, date and piece, and due to the ceuse(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner stated.

1 ☐ Yes 2 ☐ No

29d. Deta signed (Month, Day, Year)

Location (Street end Number or Rurel Route Number, City or Town, Stata)

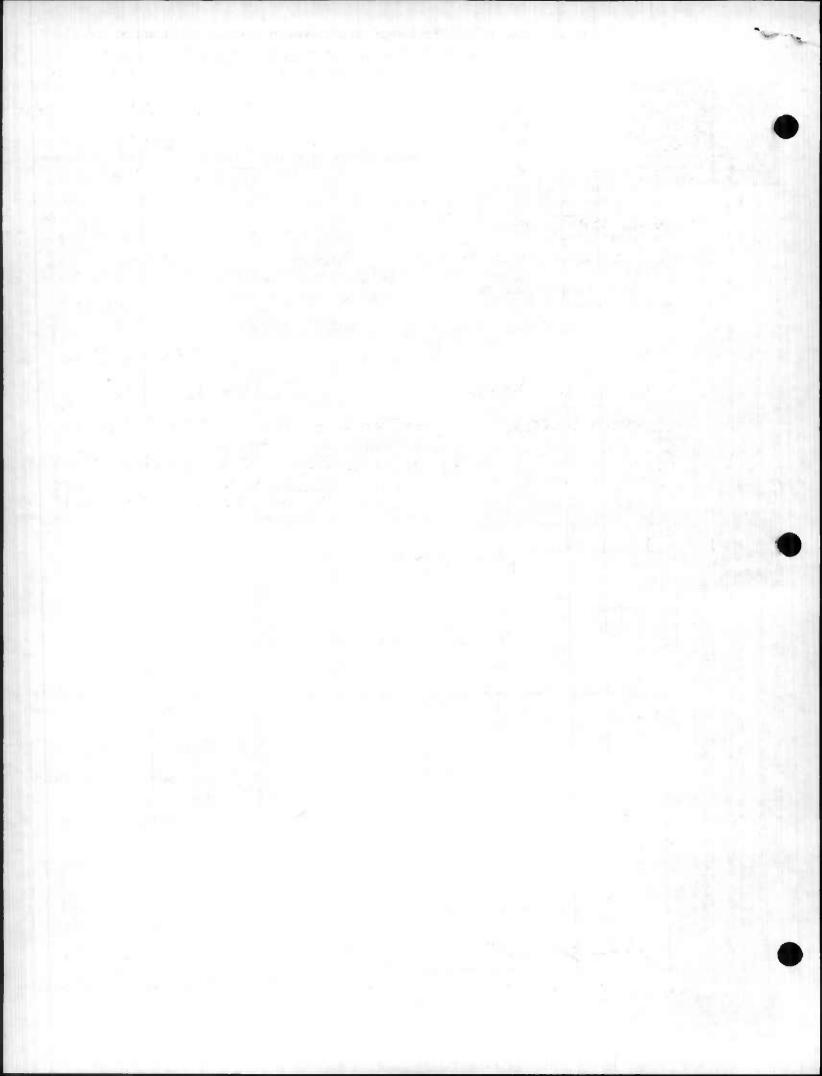
D32543

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

30. Name end eddrass of person who complated cause of deeth (Item 23e) (Type, Print)

7505 OSLER DRIVE TOURON ROMBIRG IARK 31. Deta filad (Month, Day, Yeer)

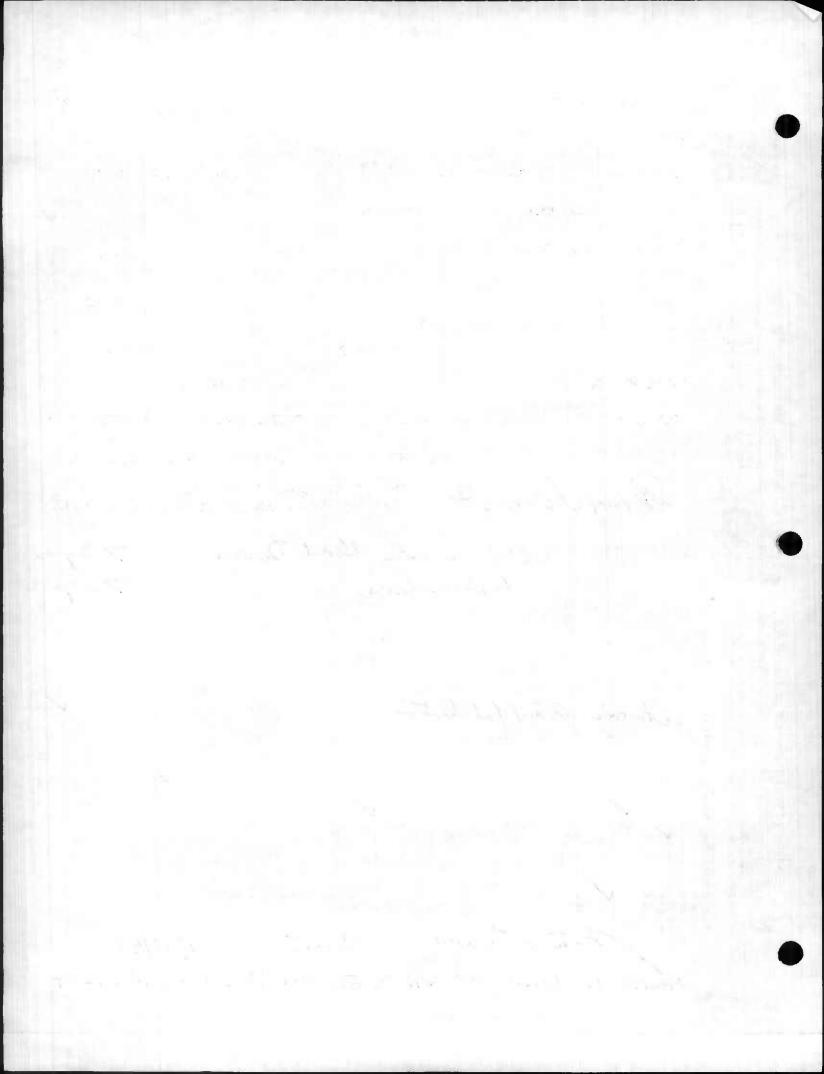
JAN 28 1998 3 Finalstree's Signeture



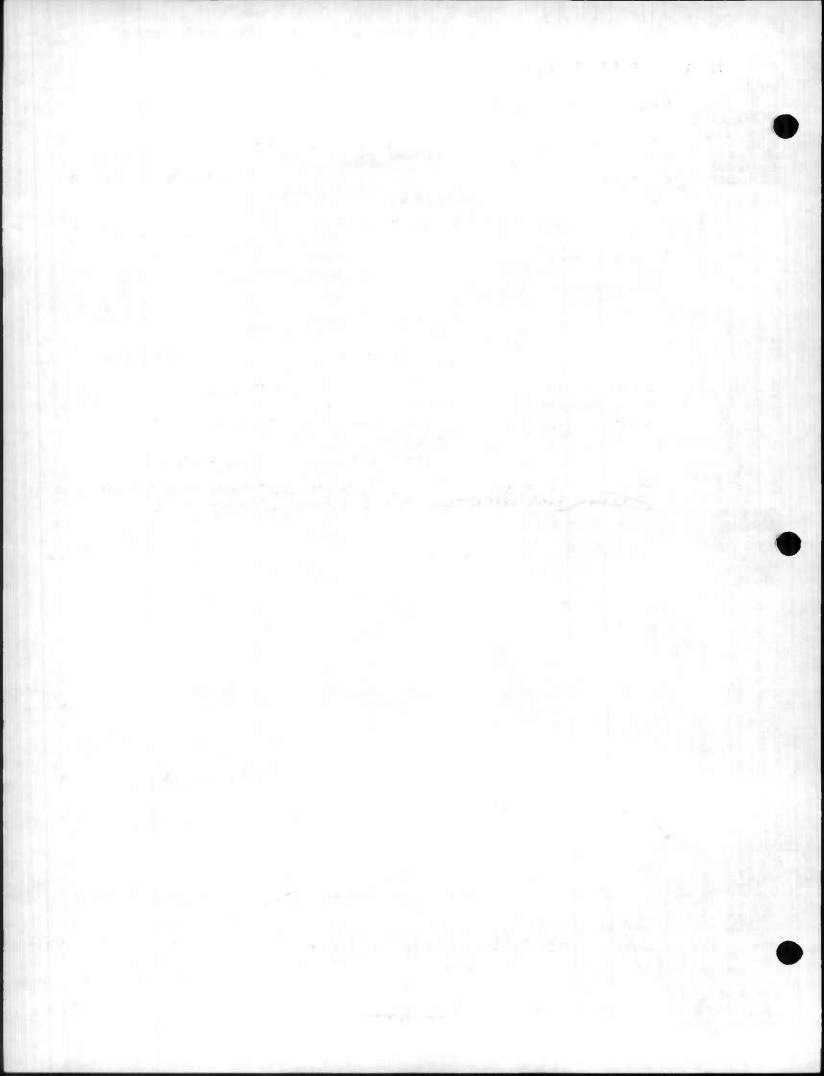
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 5:53PM MARY MAGDALEN ROLLAND 19, /Medical 4b. City, Town, or Location of Death 1998 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW BALTIMORE CITY If Under 1 Yaar If Under 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 20F 220-20-8414 98 Yrs. Director MARYLAND SEPT. 1,1899 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits show ns 23a or 28a-f shov MD BALTIMORE EASTPOINT Director 1 ☐ Yes 2 No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1046 OLD NORTH POINT ROAD 21224 U.S.A. by Funeral Items 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - American Indian, Black, White, etc. troumatic event, the Medical Examiner filed within 72 hours efter 1 Never Married 2 Married 1 ☐ Yes XX No If Yes, Give Year or Dates: 21215-0020 ŏ 1 ☐ Yes XX No Specify: Specify: 3 ₩ Widowed 4 Divorced "natural". WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grade com 16b. Kind of Business/Industry completed) I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 8 Pages 1 end 2 should be filled nent of Health end Mental Hygi Int: If Item 27 is marked other Maryland 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES FOSTER MARTHA LOCKMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health er important: If Item 27 is any injury or other treu JOSEPHINE RUTH 7232 BRIDGEWOOD DRIVE. BALTIMORE, MARYLAND 21224 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) OAK LAWN CEMETERY 1/22/98 BALTIMORE, MARYLAND 21. Signature of Funeral Service Lices 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVENUE BALTIMORE, MARYLAND 21224 23a. Part 1. Entar the disease, or compilications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physiclan** /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner erisderosis The lew requires that the death certificete be executed buriel-tran Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated avents resulting in death) Last end Due to (or as a consequence of) .O. Box 68760. physician Physiclan/Medical the Due to (or as a consequence of): USB BSU Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse givan in Part I. 23b. Did tobacco use contribute to the causa of death? signed by th 1 Yes 2 No 3 Probably 4 Unknown 0 Records, by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to complation of causa of death? Completed this certificate 1 Tyes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physicien: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this d in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi 29b. Signature and title of the A. (aro 29c. License number 011150 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MELITO M. TORRES, MO 444 5, ELLWOOD AVE, BALTO, MD 21224 32. Regi ruhie Davidson-Randelle 31. Date filed (Month, Day, Year) State Registrar JAN 28 1998



State of Maryland / Department of Health and Mental Hygiene Item 10c Per FH Film G755 1-28-98 rja Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Date of Deeth Month **Physician** 22, 1998 Emilia 11:30pm Silgalis January /Medical 4e. Facility Neme (If not institution, give Greet and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore
If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Johns Hopkins Bayview 5. Sociel Security Number 7. Age (In yrs. lest birthday) If Under 1 Year Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□ M 2♥ F Months Days Yrs. Director 217-30-5002 85 March 20, 1912 Latvia the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Baltimore **ARBUTUS** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? death with 1038 Circle Drive 21227 Funeral USA 12. Wes Decedent Ever In U,S. Armed Forces? 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. permit. Pages 1 end 2 should be filled within 72 hours after to Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or ite any finlury or other traumatte event, the Madical Engine 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Tailor Shop 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Francis Semanis 10 Anele Radrevicus 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Silgalis-son 608 Savage, Highlandtown, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 KBuriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Loudon Park Cemetery 1/26/98 Baltimore, MD 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Gary L. Kaufman Funeral Home at Meadowridge Memorial Park, 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel Sepsis days disease or condition resulting in death) Examiner Due to (or es e consequence of): Physician/Medical Examiner siclan and buriel-trensit the death certificete be executed Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): physician s the burie Box 68760 Due to (or es e consequence of): es P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 V Unknown signed t Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy pege 2 s 2 No 1 ☐ Yes 2 No 1 Yes this certificate Division of Vital or Attending Physician: director Be 25. Wes cese referred to medical exeminer? 28. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 inpatient 2 ER/Outpetient 3 DOA Certification: To funeral 27. Manyer of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Metural 5 Pending investigation death. 1 Yes 2 🗆 No efter death Director: A d in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funeral C completely filled the Hospital edicai 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted.
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) January 22, 1998 eddress of person who completed cause of deeth (Item 23a) (Type, Print) e end Hopkins Bayview medical Center, Baltiman Rennert- Ariev Jodi Johns 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State JAN 28 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death Item: 10c per F.H. G-755 1/28/98 reb 1. Decedent's Neme (First, Middle, Last) **Physician** Joseph Thomas Charles Slechter /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b City Town or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER 7. Age (In yrs. last birthday) If Under 1 Year 5. Sociei Security Number **Funeral** 1 M 2 F Deys Director 216-03-7774 93 Yrs Usuel Residence of Decedent the Marylend 10a Stete 10b. County 10c. City, Town or Location If flem 27 is marked other than "natural", or flems 23e or 28e-f show or other traumatic event, the Modical Examiner must be notified at MD Baltimore Towson PERRY HALL Director 10e. Street and Number filed within 72 hours efter death with Hygiene.

4028 E. Joppa Rd.

1 Never Married 2 Married

3 Widowed 4 Divorced

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiens, important, if flow 27 is marked other than any Injury or other trainment.

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Certification:

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11. Marital Stetus

4c. County of Deeth TOWSON BALTIMORE If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) March 22 1904 Maryland

25, 1998

3. Time of Deeth

5:00AM

10d. Inside City Limits 1 ☐ Yes 2 ☐ No 10f. Zip Code 10g, Citizen of Whet Country?

2. Dete of Deeth

JANUARY

Month

21236 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: White

16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+)

11 Compositor Printing 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme)

Thomas Slechta Agnes Vanik 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print)

7 Candlestick Dr., Lutherville, MD 21093 Jean M. Petts/daughter 20c. Location - City or Town, Stete 20a, Method of Disposition Dete

20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 Donation 5 Nother (Specify) Entombment Dulaney Valley Mausoleum 1/28/98 Timonium, MD 21093

Signature of Fugural Service Licenses 22. Name end Address of Fecility Lemmon Funeral Home

Lemmon Or 23a Part Loner find disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximeta Intervei Between Onset end Deeth Immediete Ceuse (Final 10 hours disease or condition resulting in deeth)

Due to (or es e consequença of) Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last

Due to (or es e consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to

completion of cause of death?

25. Wes case referred to medical 26. Place of Deeth (Check only one) 1 ☐ Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident

6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) end manner stated. 29a. Certifier

29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year)

m). uarnier

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Bultonore nd N. charles T. GuaRNIRRI 6569

31. Date filed (Month, Dey, Yeer) State 28 1998 Registrar

32. Registrer's Signeture Julia Pavidson-Randalle

DHMH 16 Rev 6/95

Box 68760. certificate be P.O.

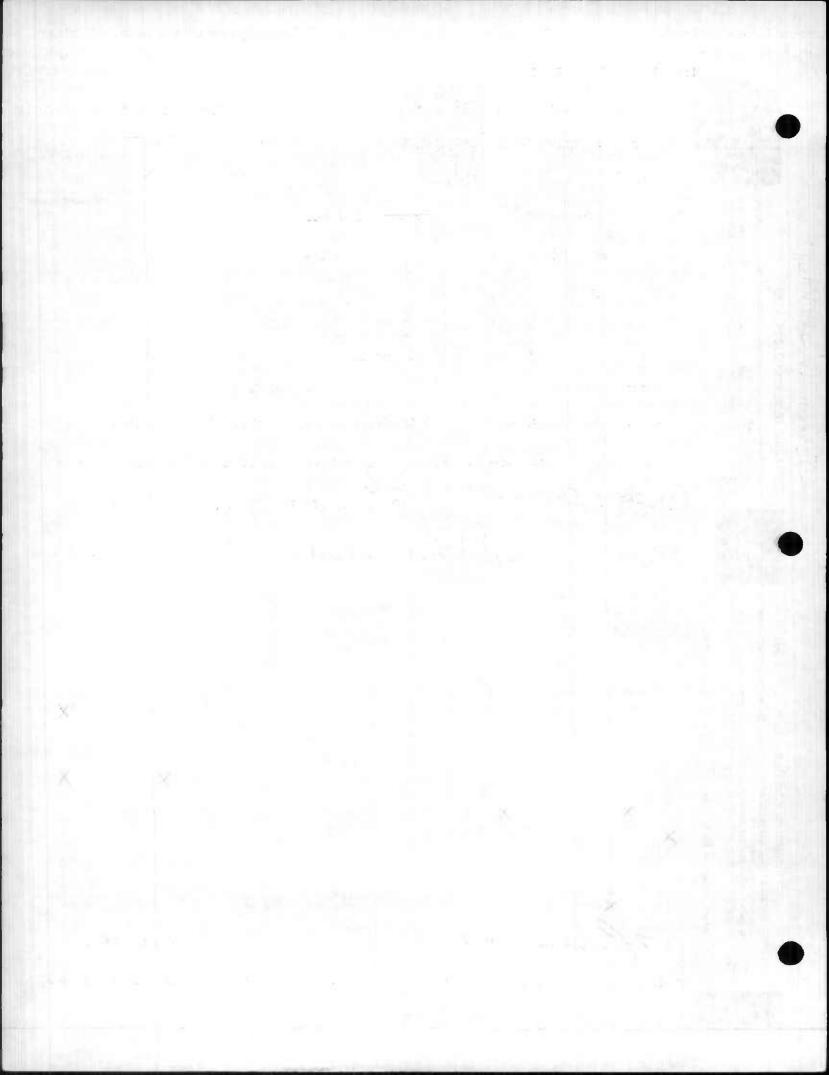
Joseph T. Slechter

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To the Hospital or within 24 hours eff To the Funeral Di completely filled in

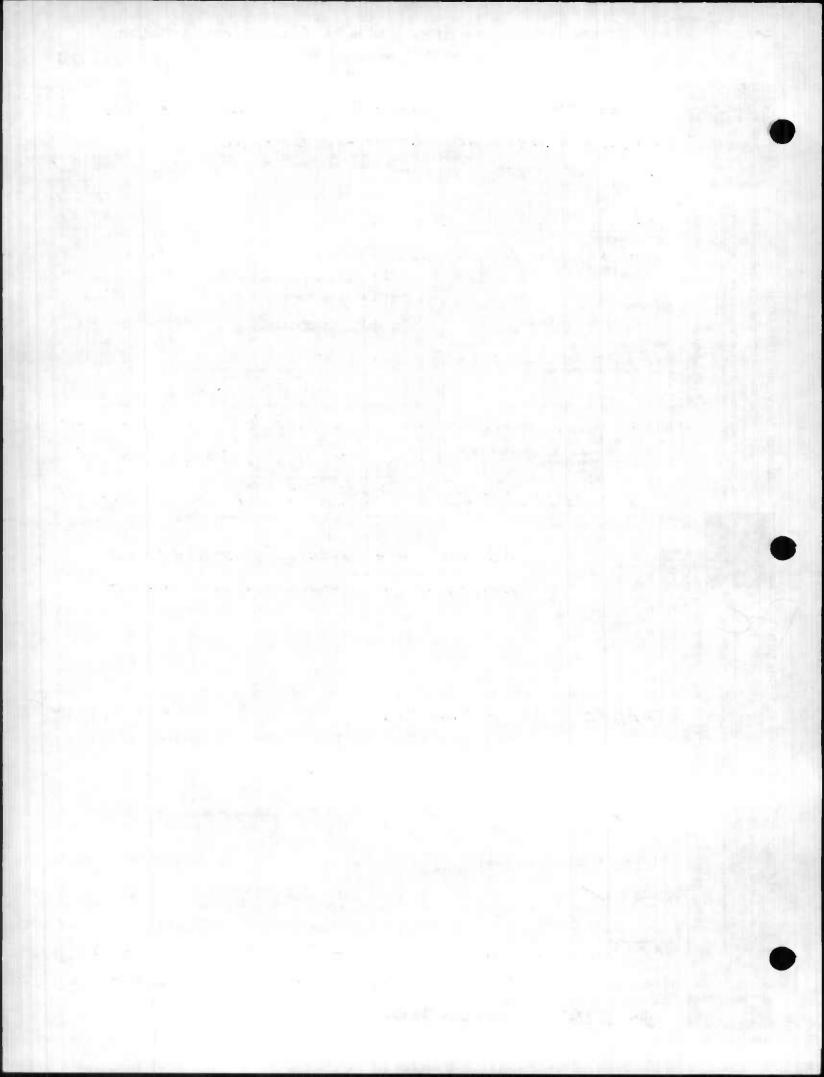
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State of Maryland / Department of Health and Mental Hygiene 2066

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	23a. Part1. Enter the disease, or con	nolicetions that cau	sed the death. Do	not antar tha mo	da of dvi	ng, such as	cardiac or	raspiratory erra	ist.		Approximata		
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WRC 98-0258-510 CARL

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ate of Maryland / Department of Health and Menta	I Hygiene () Ω	02	nc.	
Certificate of Death	Reg. No.	02	00	

SH	OVER					Cer	tificat	e of	Death	R	leg. No.	UZ	061		
	Physicia /Medic		1. Decadant's Nama (First, Middla, Carl	Last)		Shover				2. Data of Dea JAN . 17	th Day 998	Yaar	7:24 AM.		
Exami		_	4a Facility Nama (If not institution, 601 WYAN OAK	4b. City, Town, or Lo			4c. County of Death N/A								
	Funeral Director		272-16-4027	Sex 1∆M 2□F	7. Aga (In yrs. 76		If Undar Months	1 Yaar Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth ADT1 2	4,1921	9. Birthplac Country, Unknow	a (Stata or Foraign) WN		
	Merylend	Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location Baltimore								10d. Insida City Limits 1 Yas 2 □ No					
	uth with the	Funeral Director	10e. Street and Number 601 Wyan Oak	Coda 2121	8	1	10g. Citizen of Whet Country? USA								
11215-0020 within 72 hours effer death with the Meryland ene. than "natural", or items 23s or 28s-f show he Medical Examiner must be inclifted as	urs efter deel	þ	11. Marital Status 1 Navar Marriad 2 Married 3 Widowed 4 Noivorced	Armed Fo 1 X Yas If Yas, Giv	12. Was Decedant Evar in U,S. Amed Forcas? 1			denf of H cify Cube 2 No	lispanic Origin? (Sp an, Maxicen, Puarto Specify:	ecify Yas or No- Ricen, atc.)		e - Amaricen ck, Whita, atc			
21215-0020	2 should be filed within 72 hours end Mentel Hygiene. Is marked other than "natural", raumatic event, ma Modical Ex-	Completed	15. Decedant's (Specify only highast Etementery/Secondery (0-12) UNKNOWN	Education grada complated) College (1	-4or 5+)	16a. Decedi (Giva k lifa. D	rind of wo O NOT us	el Occup rk dona sa retira	eation during most of work d)	ing	16b. Kind of B		fry		
ore, Maryland	parmit. Pages 1 and 2 should be filed within 7: Department of Metalls and Mental Hygien. Important: if item 27 is marked other than "many injury or other traumatic event, the Mexidica.	To Be C	17. Fafhar's Nama (First, Middla, Le	st) Unkn	own				18. Mother's Nema	u (First, Middle, Unknown	Maidan Suman				
	end 2 sho saith end ? 27 le ma er traume		19a. Informant's Nama/Ralationship Unknown	(Type, Print)					and Number or Run Unknown	al Routa Numbe	r, City or Town,	State, Zip Co	ode)		
	Peges 1 end nent of Health ant: if item 27 ury or other t	20a. Method of Disposition 1													
Balt	permit. Pege Department of Important: If any Injury or pace.		21. Signafura of Funaral Service Li	ensee			Stall	ling	ss of Facility S Funeral ntain RD.			21122			
	Physician /Medical Examiner		23a. Part1. Enter the chasse or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)		rioscle	fh. Do nof anfa	ardi	a of dyir	ng, such as cardiac	or raspiratory an	ast,	. Ar	pproximata tarval Batween nsat and Death		
90,	deeth cartificate be exacuted e attending physician end of for use as the buriel-transit	i Examiner	Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Ceuse (Diseese or Injury that initiated avants	b	Due to (d	or as a consequ	uence of):								
Box 68760,	eeth certificate l attending physi for use es the l	8	fhat Initiated avants rasulting in daath) Last	d	Dua fo (d	or as a consequ	ence of):		_						
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Records,	S G	Completed by								24a. Was e perfor		availa	eutopsy findings abla prior to plation of causa ath?		
=	ysiclan: The lev is certificete hes director, pege 2	Be Com	25. Was casa refarrad to medicel						26. Placa of Daat	1□ Y	as 2⊠No	1 🗆 Y	′as 2□ No		
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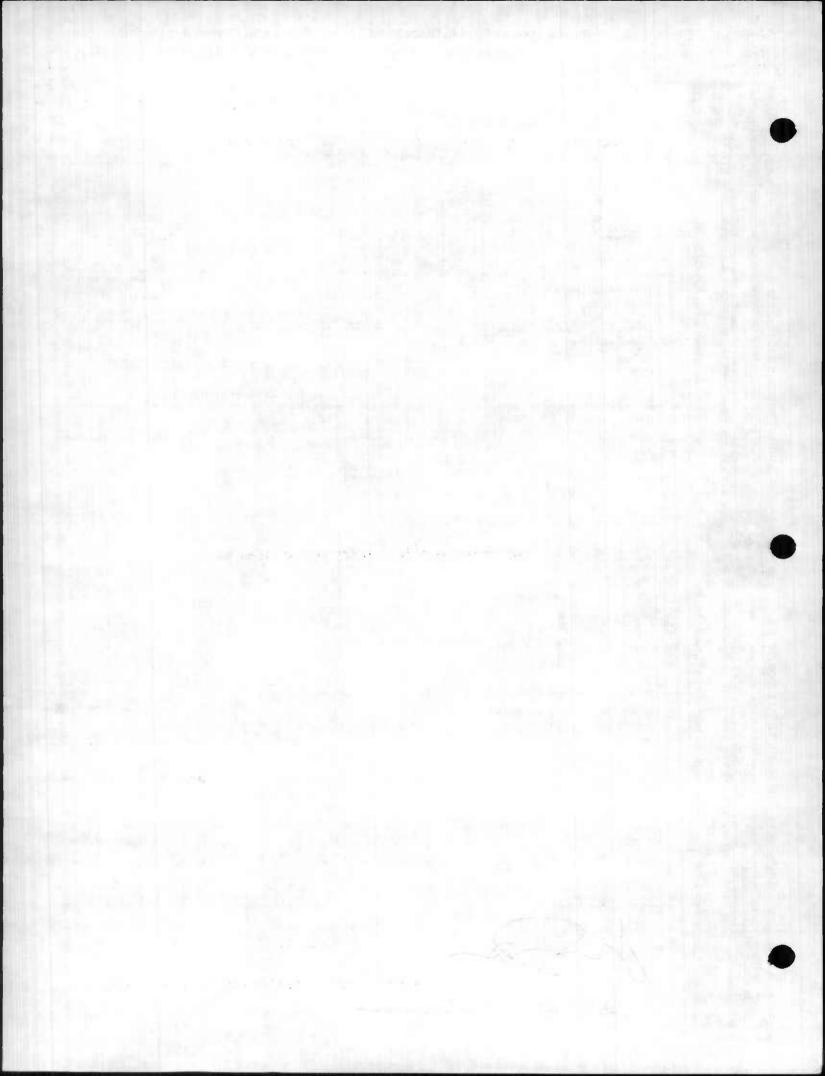
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30. Nama and digrass of paron who complete Ann Dixon M.D. 32. Albigrar's Aggains Pandale

causa of death (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

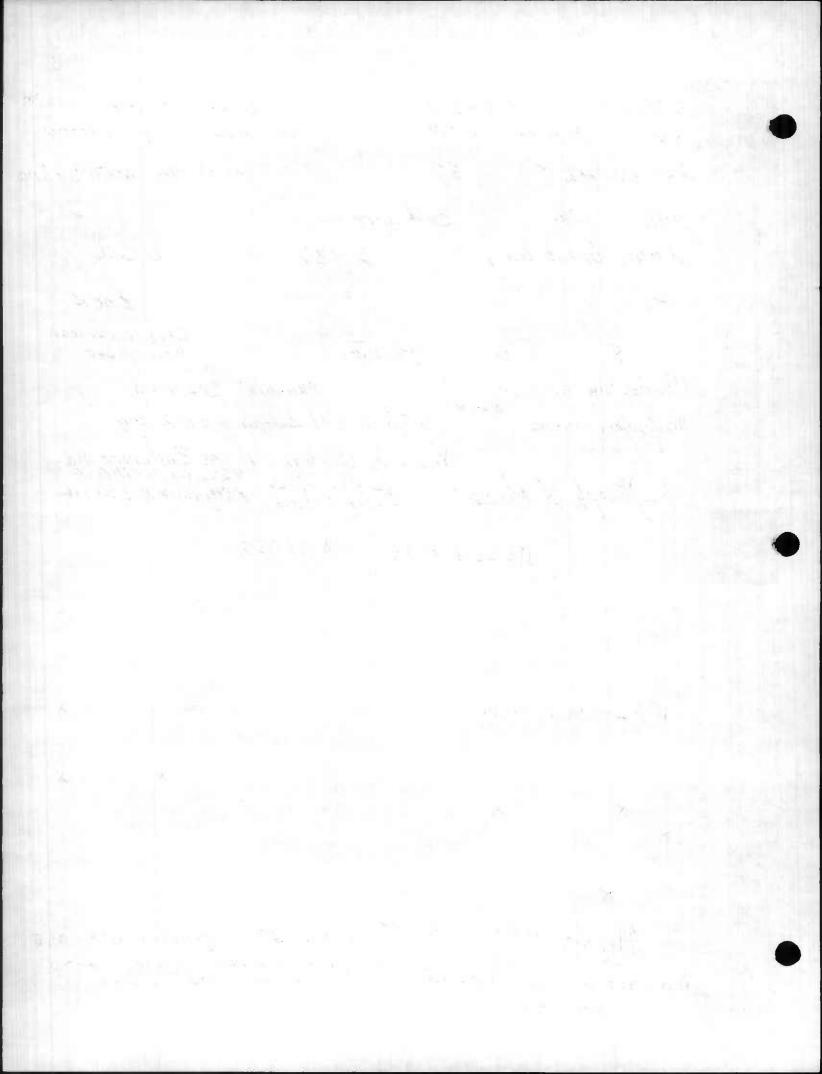
O.C.M.E.

JAN. 17, 1998



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Day **Physician** 11:05 PM CHARLES SHEPPARD JANUARY 1998 4e. Fecility Neme (If not institution, give street end number) /Medical 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** HOSPITAL NORTH WEST BALTIMORE BALTIMORE If Under 1 Year II Under 24 Hrs.
Months Deys Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Funeral 100M 2□ F ZZO - 07-0682 Usuel Residence of Decedent 220 Yrs. Director filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town of Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or floms 23a or 28a-f shov traumatic event, the Medical Events of mast be notified at Baltimore Completed by Funeral Director 1 PYes 2□ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1136 Way 12. Wes Decedent Ever in U,S.
Armer Forces?
1 ZYes 2 No
1 Yes, Give
Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Maritel Status Race - American Indien, Black, White, etc. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Black Specify: Specify: 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life_DO NOT use retired) 16b. Kind of Business/Industry afro-american and Mental Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) inler Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Pages 1 and 2 should be fill ment of Haalth end Mental H Be harles Sheppard Margare Sheppar 19e. Informant's Name/Reletionship (Type, Print) (10160) 19b. Mailing Address (Street end, Number or Rural Route Number, City or Town, Stete, Zip Code) if item 27 is Ms, Cynthia owens t. pultimore, Md 21209 20b. Place of Disposition (Name of cemetery, cremetery or other) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removel from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signiture of Funeral Service Licer Baltimore, md. 21216 unera 23a. Pert / Inter the clease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Physician DISEASE /Medical Immediate Cause (Finel DLZEHIMERS disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be axecuted burial-trensi Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest and Due to (or es e consequence of): P.O. Box 68760, the Due to (or as e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? filled in by the funeral director, page 2 should be detac MALNUTRITION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, by 24b. Were eutopsy findings eveilable prior to completion of ceuse of death? Completed 24a. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 No 1 🗌 Yes of Vital To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funerei Director: After this certifica Be 25. Wes cese referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 ★npatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Division 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Exeminer: On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated. PHYSICIAN 29c. License number 23 29b. Signeture and title of certifier 29d. Date signed (Month, Dev. Year) ANVARY 23 RD / HOUSE FANVARY BALTIMORE 3745 STREAM ROAD 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) HARISH. HYV ERAHALLI 31. Dete filed (Month, Day, Year) 32. Registraria Signeture State JAN 28 1998 wha Davidson Registrar



32

State Registrar Javia

e filed (Month, Day, Year) 32. F

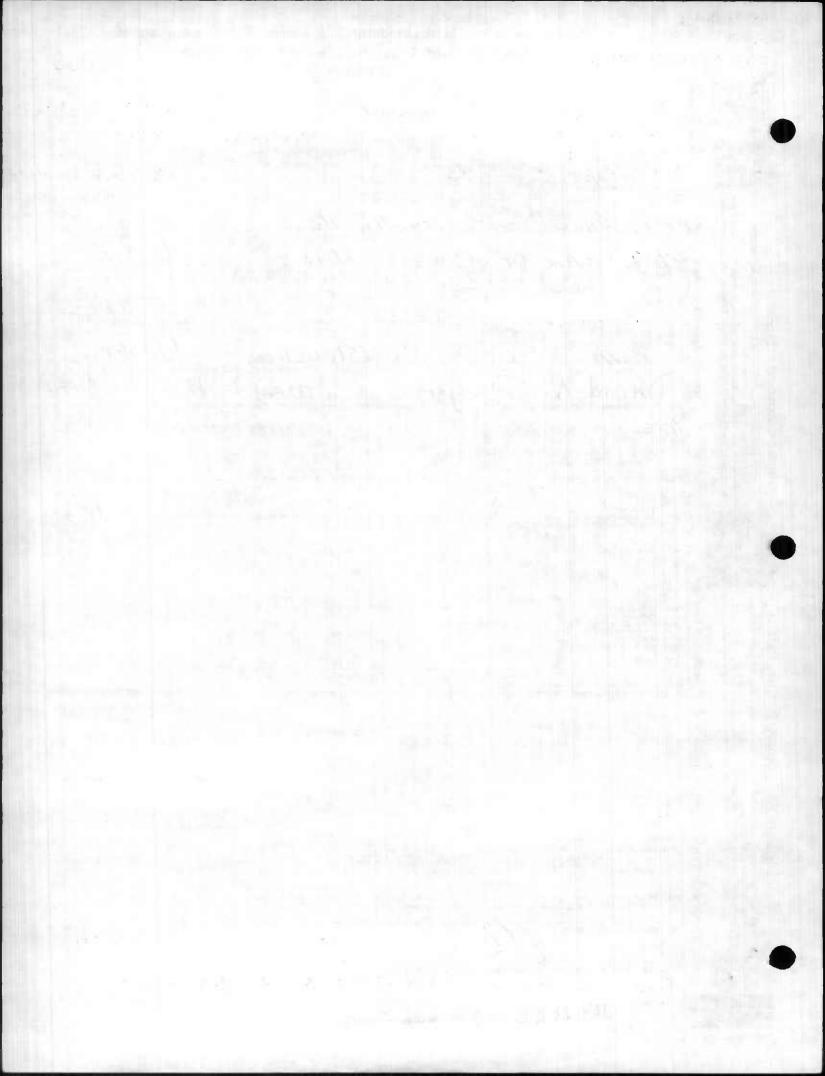
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Powler

32. Registrar's Signeture

Julia Davidson-Randale

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death Month **Physician** PAUL EUGENE SCHUDER Jan 24, 1998 11:15 PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3167 Ryerson Circle, 21227 Baltimore Baltimore 5. Social Sacurity Number If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) Aug 30, 1940 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** X M 2 F Months Days Hours Min Yrs. 57 Director 217-38-1741 Maryland Usual Rasidance of Dacedani 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3167 Ryerson Circle 21227 USA deeth 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. filed within 72 hours efter 1 ☐ Yas 2 ☐ No If Yas, Giva 1 ☐ Navar Marriad 2 ☐ Marrled Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: py White 3 Widowed 4 X Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Hygiene. Elamantary/Secondery (0-12) College (1-4or 5+) Plant Employee Nestles Corp. 0 marked other 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) permit. Pages 1 end 2 should be filk Depertment of Heelth end Mentel Hy Important: If Item 27 Is marked oth any Injury or other traumatic event Be Howard W. Schuder, Sr. Lillian Wolfe 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rurel Routa Number, City or Town, Stata, Zip Code) Ms. Alma L. Condon (Sister) 3167 Ryerson Cl., Baltimore, Md. 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 【Cramation 3 ☐ Ramoval from Stata Green Mount Cemetery Jan 26, '98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signatura of Funaçal Servica Licansaa 22. Nama and Addrass of Facility Kevin E. Ecker McCully-Polyniak Funeral Home 237 E. Patapsco Ave., Balto., Md.

23a. Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21225-1856 Approximeta Intarval Batween Onsat and Death **Physician** /Medical Immadiata Causa (Final 2 months Cancer disaasa or condition rasulting in death) Examiner Examiner -transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Ceusa (Disaase or Injury that Initiated evants rasulting in death) Last pue Dua to (or as a consequence of): physicien er Box 68760, Physician/Medical the Dua to (or as a consequance of): 98 for use es P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Pres 2 No 3 Probably 4 Unknown signed to Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? certificate has been si rector, page 2 should Completed 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attanding Physician: 24 hours effer deeth. director, Be 25. Was casa rafarrad to medical 26. Piece of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Yaar) 27. Manner of Death 28b. Tima of 28c. Injury et Work? 28d. Dascribe how Injury occurred After 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation d in by the 2 Accidant 6 Could not be dataminad 3 Suicida 28f. Location (Street end Number or Rurel Routa Number, City or Town, State) 28a. Pleca of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours of To the Funeral DI completely filled in Cartifying Physician: To the bast of my knowledge, deeth occurred et the time, data and place, and due to the ceuse(s) end menner es steted.

2 Madical Exeminar: On the basts of axamination and/or investigetion, in my opinion, death occurred at the time, data and place, and due to the causa(s) end manner steted. 29a. Certifian Medical Signature and title of certifier 29c. Licensa number 29b. 29d. Data signad (Month, Day, Year)

State Registrar

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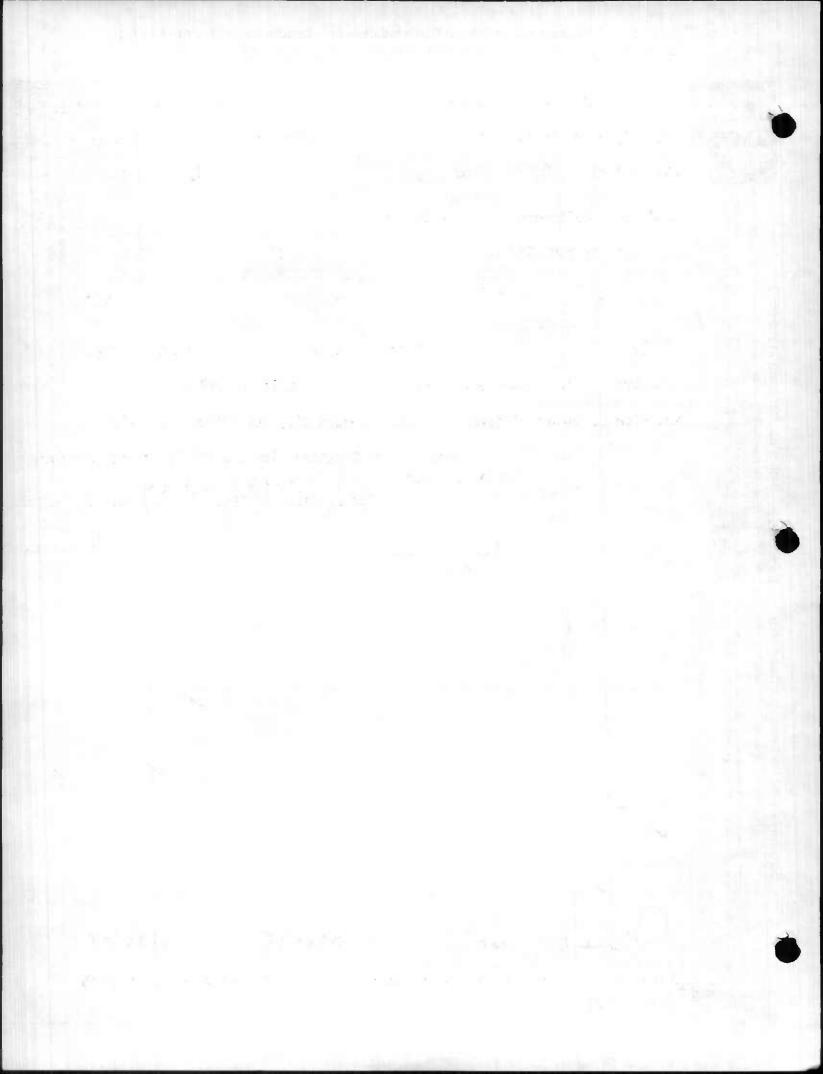
addrass of person who complated cause of death (Itam 23a) (Type, Print)

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MD 21230



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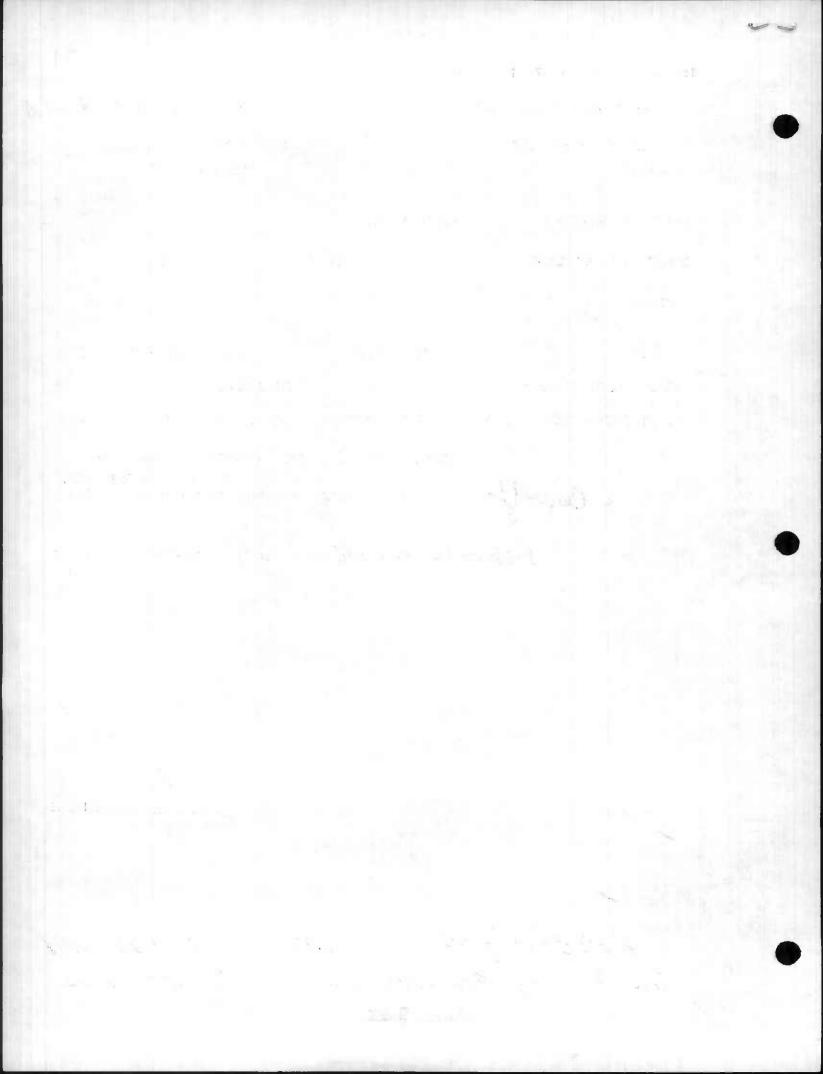
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and address of person who complated cause of deeth (Item 23e) (Type, Print)

32. Registrar's Signature

Balls. MD 21229

rar JAN 28 1998 gulia



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3 Time of Death TROMBERI Month
THNUARY 20, 1998 ANZELMO **Physician** 1630 Hrs /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Deeth
BALTIMORE **Examiner** RANDALLITOUR NORTHWEST HUSPITAL 7. Age (In yrs. last birthdey) | If Under 1 Yaer | If Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year) | 9. Birthplece (Stett (Month, Dey, Year) | ULY 31, 1921 | Maryland 5. Social Security Number 6 Sax Birthplece (Stete or Foreign Country) **Funeral** 1♥M 2□F 220-09-4143 Director Usuel Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 Yes 2 No Md. Baltimore Woodlawn 10e Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 3002 Essex Rd. Funeral 21207 death USA 11. Maritel Stetus 12. Was Decedent Evar In U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. filed within 72 hours efter 1 ☐ Yes 2 No 1 Navar Married 2 Marriad 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16h Kind of Business/Industry ulth end Mental Hygiene. 27 Is marked other than "r r treumatic event, me Meo Elementery/Secondary (0-12) College (1-4or 5+) 8 Cab Driver Transportation Baltimore, Maryland 17. Fether's Name (First, Middla, Last) 18. Mother's Nema (First, Middle, Meiden Sumeme) Pages 1 and 2 should be 1 nent of Health end Mental I Joseph Tromberi Victoria De Rose 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Depertment of Health or Important: If Item 27 Is any Injury or other treu Jenny McCarthy - friend 2873 Rona Rd., Balto., Md. 21207 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 1/24/98 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore Washington Crm. Laurel, Md. 22. Name end Address of Fecility 21. Signeture of Funeral Service Licen Gary L. Kaufman Funeral Home @ Meadowridge MP 7250 Washington Blvd., Elkridge, Md., shock, or heart failure. List only one ceuse on each line. Approximate Interval Betw Onsat and Death Physician RESPIRATORY FAILURE /Medicai Immediete Ceuse (Final diseese or condition resulting in deeth) Examiner Physician/Medical Examiner PNEUMONIA Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of): P.O. Box 68760. Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown EPILEPTICUS, CVA Records, Completed 24b. Were eutopsy findings aveilable prior to 24e. Wes en eutopsy performed? completion of ceuse of death? 1 Yes ZUNo Division of Vital To the Hospital or Attending Physician: within 24 hours aftar deeth.

To the Funeral Director: After this cardifica completely filled in by the funeral director; p Be 25. Was cese referred to medicel examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 ☐ Yas 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted.

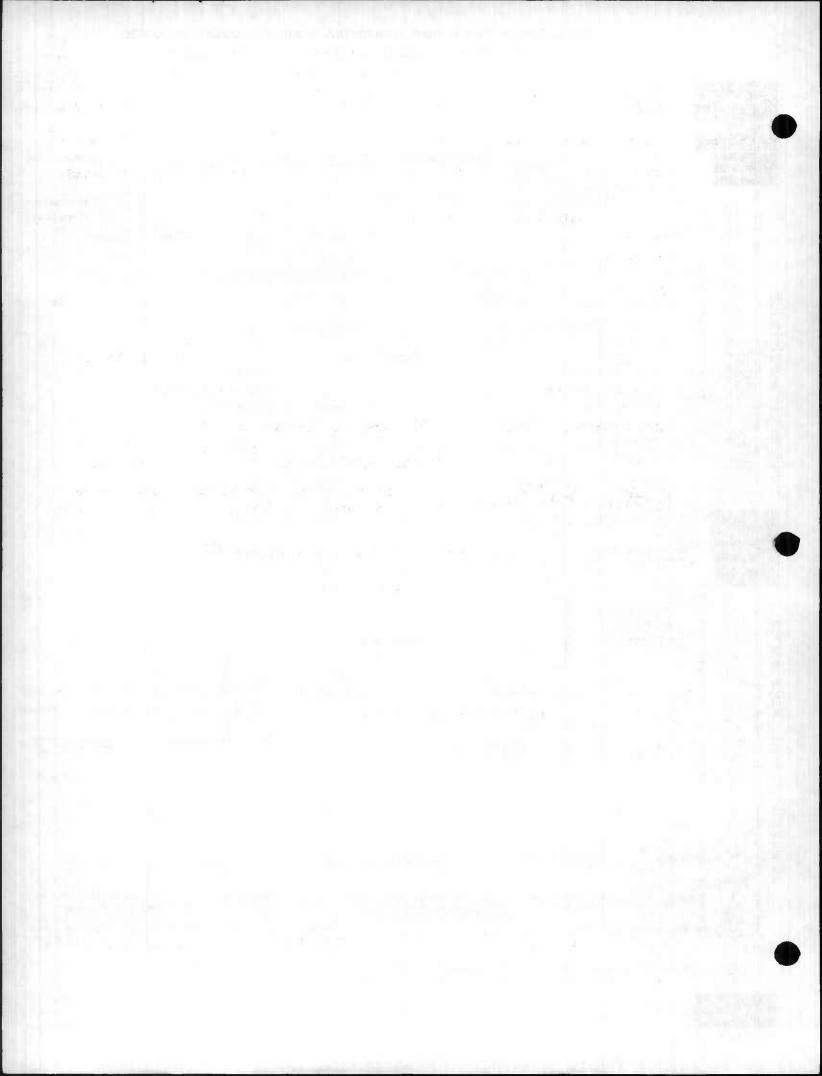
| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifiar 29c. License number 29d. Dete signed (Month, Day, Year) 37733 JANYARY 20, 1998 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) C - NAVI MD, NHC, SALTO, MD 21133

32. Registrer's Signature
Julia Davidson-Rondelle

DHMH 16 Rav 6/95

State Registrar 31. Dete filed (Month, Dey, Year)

28 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth TOOKER. **Physician** BERTHA Month · 40 ACC Januar /Medical 4e. Fecility Neme (If not institution, giva streat and number) 4b. City. Town, or Location of Deeth 4c. County of Daath Examiner Cen kere

H Undar 1 Yaar - Harford Garden
6. Sex 7. Aga (In yrs DP/7
If Under 24 Hrs. 7. Aga (In yrs. last bighday) 9. Birthplece (Steta or Foreign **Funeral** Deys 1□ M 20 F Yrs. Director Decedent filed within 72 hours after death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evaluiner maint be notified at 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 1, Completed by Funeral Rece - American Indian, Bleck, White, etc 11. Merital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Yeer or Dates: 20 No 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced Maryland 21215-002 MERICAN 16a. Decedent's Usual Occupetion
(Give kind of work done during most of working
life. DO NOT use retire?) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) nd Mental Hygiene. markad other than Elementery/Secondary (0-12) College (1-4or 5+) 17. Fether's Nema (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked othen any Injury or other traumatic evant 18. Mother's Name (First, Middle, Be 0 Print) (Nephew 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street end Number or Rurel Route Number, City or md,2111 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20a. Method of Disposition 20c. Location - City or 1 Burial 2 Cramation 3 Removal from State Md. 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signature of Funerel Service Licensee 22. Name end Address of md. 21216 ntl. Enlar the diseesa, or complications that caused the death. Do not enter the mode of dying, such as cardi cook, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Physician /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Examiner The law requires that the death certificate be executed use es the bunal-transit Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Lest pue Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Dua to (or es a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of deeth? signed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown by director, page 2 should be Be Completed 24a. Wes en eutopsy performed? 24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? s been this certificate has 21 No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 200No 2 1 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Naturel 2 Accident 1 Tes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Numbar, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, daath occurred et the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier Medicai

State Registrar 31. Data filed (Month, Day, Year)

29b. Signature and title of certifie

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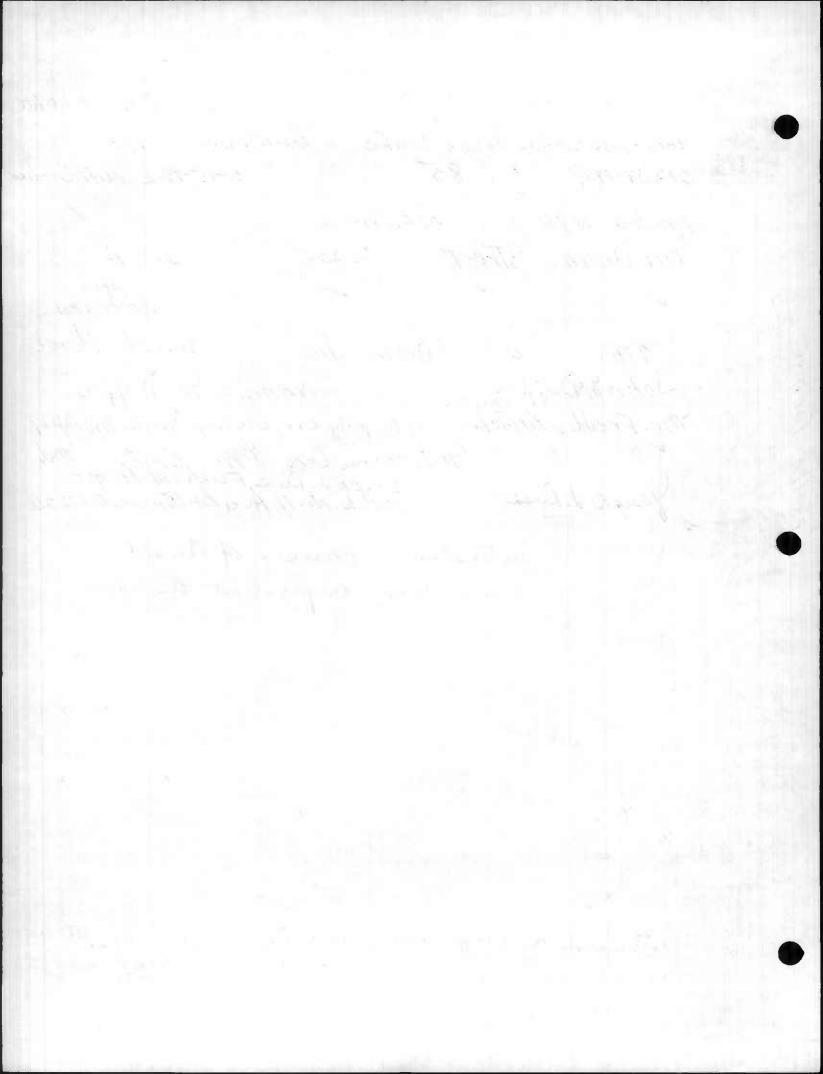
30. Nema and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 3 (REESH 5670 The Alamada, Ballimole, F 32. Registrar's Signeture wha Davidson

29c. License number

red

29d. Date signed (Month, Dey, Year)

21239



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month 01 21 4:30 am. 98 Duane Edward Thorpe /Medical 4a. Facility Neme (If not institution, give straat and number) 4h City Town or Location of Daeth 4c. County of Deeth Examiner ST. MARTINS HOME (LITTLE SISTERS OF THE POOR) CATONSVILLE BALTIMORE If Under 24 Hrs. Hours Min. 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) **Funeral** Birthplece (State or Foreign Country) tx□M 2□F Months Deys Yrs. Director 212-05-3857 MARCH 26,1908 BALTIMORE, MD Usual Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Insida City Limits BALTIMORE CATONSVILLE Director 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 601 MAIDEN CHOICE LANE 21228 U.S.A. Funeral 12. Was Decedent Ever In U.S. Armed Forcas? 1 □XYes, 2 □ No If Yes, Give Yeer or Datas: WW II Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Raca - Amarican Indien, Bieck, White, atc. 1 ☐ Naver Married 2 ☐ Married 1 ☐ Yas 2 ☑ No Specify: þ Specify WHITE 34 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) RETAIL SALES BALTO GAS & ELECTRIC 12TH GRADE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Be ARTHUR THORPE AGNES WALL 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 10115 CHARINGTON ROAD - COCKEYSVILLE, MD. 21030 ANN T. McLAIN (DAUGHTER) 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 □XBuriai 2 □ Cramation 3 □ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) DULANEY VALLEY CEMETERY 1/24/98 COCKEYSVILLE, MD 21, Signature of Funeral Service Licensee 22. Name and Address of Facility
HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE - BALITMORE, MD 21229 Part 1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, nock, or heart feiture. List only one ceuse on each line. Approximate Intervel Between URDSEPSIS Immadiate Ceuse (Finel disaase or condition resulting in deeth) consequence of Mellitus Examiner Sequentially list conditions, if ony, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Physician/Medical Due to (or as a consequence of): Pert II. Other significent conditions contributing to death but not rasulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? Osteoarthritis 1 Yes 2 No 3 Probably 4 Unknown by Artero Scherotie Cardio Vasculas Disease Completed 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 TYAS 2 PNo 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Prursing Home 5 Residence 6 Other (Specify) 2 1 Yas 2 No 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death Medical Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Proeture 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyelcien: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es steted.
2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signatura end title of ertifier 29c. License numbar 29d. Date signed (Month, Dey, Yeer) 22164 30. Name engladdress of person who completed cause of deeth (Item 23e) (Type, Print) SAMBANDAN BASKARAN - 3455 WILKENS AVENUE - BALTIMORE, MD 31. Date filed (Month, Dey, Year) 22 Registrar's Signeture State JAN 28 1998 who Davidson-Gandale Registrar

DHMH 16 Rev 6/95

Peges 1 end 2 should be filed within 72 hours after death with the Manyland neat of Health and Mental Hygiene. In the Manyland Hygiene with: If ferm 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, It a Medical Examiner, must be notified at

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Important: If ite
any injury or oth

Physician

/Medical

Examiner

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the Hospital or Attending Physician: The law requires that the death certificate be executed

page 2

certificate

this funeral

After

To the Hospital or Attending within 24 hours efter death.

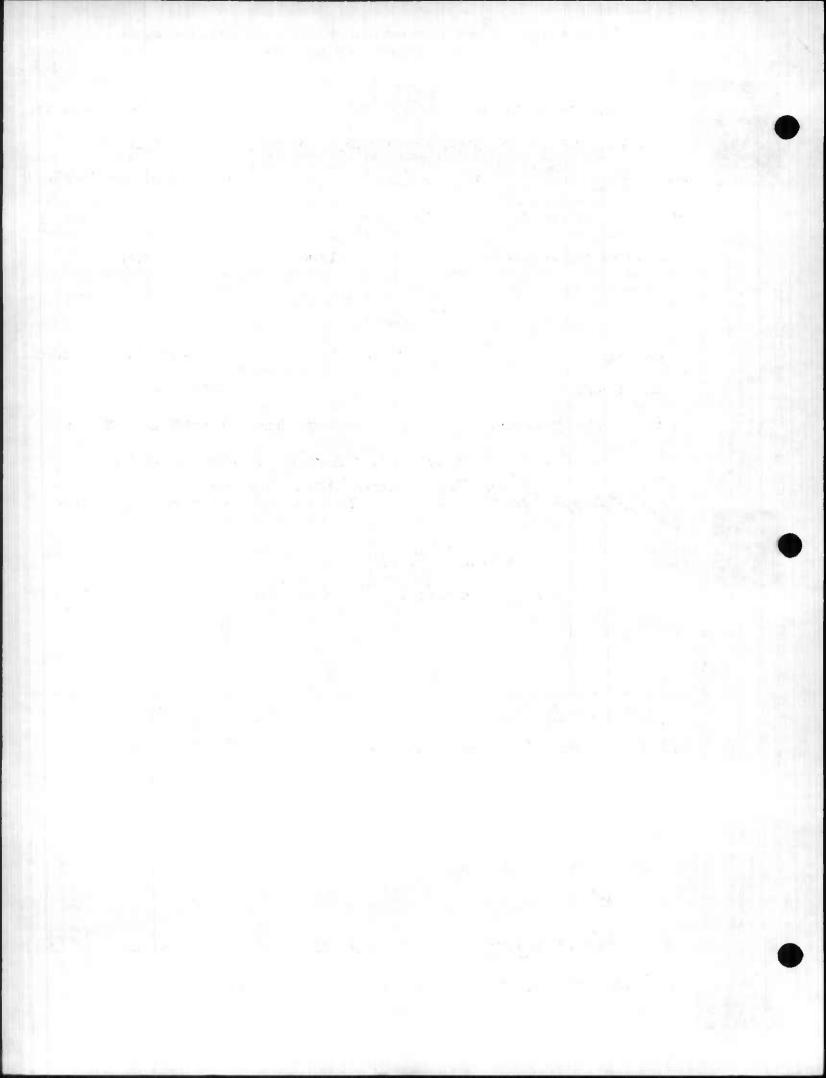
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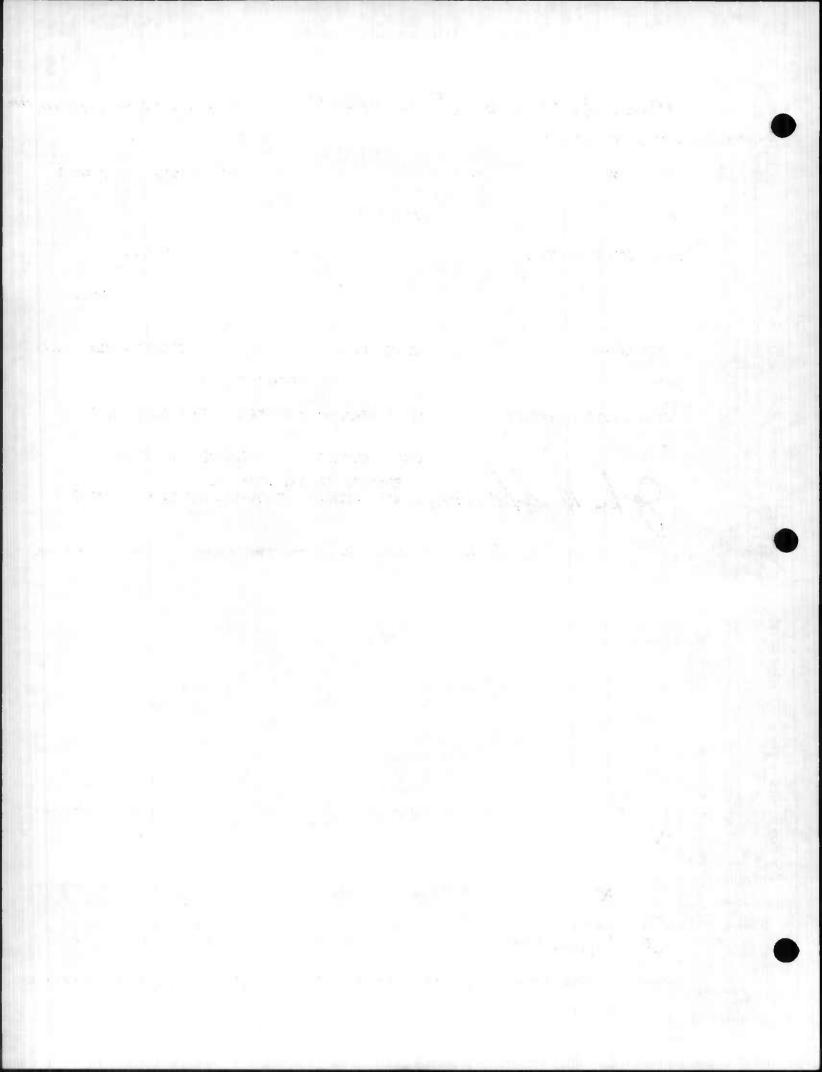
Baltimore, Maryland 21215-0020



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth HomPson Month **Physician** JANUARY 27 1998 10:10 Am /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE JOSEPH RITCHIE HOUSE 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) 9. Birthplaca (State or Foreign Funeral Deys 1□ M 25 F Months Hours Director 82 214-18-7696 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location or 28a-f show 10d. Inside City Limits Examiner ment be notified at Director MD N/A BALTIMORE 1 Yes 2 □ No 10e, Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 230 U.S.A. 21229 3150 STRICKLAND STREET Funeral death items 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or ite any injury or other traumatic event, the Healten Example. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PITTSBURG PLATE GLASS 6TH GRADE BRUSH MAKER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be MINNIE FULLER JOHN WALL 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 17201 SHEPHERDSTOWN PIKE - SHARPSBURG, MD 21782 EVELYN UHDEN (DAUGHTER) 20b. Plece of Disposition (Neme of 20e. Method of Disposition Dete 20c. Location - City or Town, State cemetery, cremetory or other place) 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 1/27/98 4 ☐ Donation 5 ☐ Other (Specify) WESTERN CEMETERY BALTIMORE 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility HUBBARD FUNERAL HOME INC. e, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, List only one ceuse on each line. 21229 4107 WILKENS AVENUE-BALTIMORE, MD Approximete Intervel Between Onset end Deeth **Physician** Immediete Ceuse (Final disease or condition resulting in death) /Medical AD ENO CARCINOMA OF THE PANCREAS / YEAR Examiner Due to (or as e consequença of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest and Due to (or es a consequença of) Box 68760, physician Due to (or es e consequença of): for use as signed by the aid to be detected for P.O. I Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 21 No 3 | Probably 4 | Unknown Records. ģ page 2 should Completed 24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy performed? peed completion of cause of deeth? hes 1 ☐ Yes 2 TNo 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this In by the funeral 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred After t Division 1 Naturel 5 Pending Investigation Injury s efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 - Homicide filled Hospital 24 hours 29a. Certifier Certifying Phyelcian: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. Medical within 24 hor To the Fune completely fi To the 29b. Bignature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) Macsiblan 30 Name and ass of person who completed ceuse of death (Item 23e) (Type, Print) MAC GIBBON MD 101 WREADSTREET SUITE 719 BALTIMORE MD 21201 31. Date filed (Month, Day, Year) JAN 28 1998 82 Registrar's Signeture
Why Davidson-Randall State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Date of Death **Physician** Samary 23 1998 Witherspoon Bernar 2:26 PM /Medical 4a. Facility Name (If not institution, giva street end numbar) Examiner Saltimore pkins If Under 24 Hrs. Hours Min. Aga (In yrs. last birthday) 5. Social Security Number 6. Sax 8. Date of Birth (Month, Def. Birthplace (State or Foreign Country) **Funeral** Deys 1**X**M 2□ F Director June 25,1970 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 KNo Director Howar mage 10e. Street end Number 10f Zip Code 10g. Citizan of What Country? 8816 Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer. Department of Health and Martal Hyglene. Important: If item 27 is merked other than "natural", or item iny inlury or other traumetic event, ITE Medical Examine Never Marriad 2 Married 1 ☐ Yas 2 No If Yes, Giva Year or Detes: 1 ☐ Yas 2 No Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 97ade 17. Father's Name (First, Middle, Last) College (1-4or 5+) lechan 18. Mothar's Neme (First, Middle, Maiden Sumeme) Witherspoon Witherspoon Emanue 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zib Code) incoln Street, Savage, Maryland 20163 8816 manue vitherspoon 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State Metro Crematory Baltimore Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph H. Brown Jr. Funeral Home, Pa. 240 N. Fulton Avenue Battimore Maryland 21217 21. Signeture of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each in **Physician** /Medical Immadiate Cause (Final disease or condition resulting in deeth) filminant liver week Examiner Due to (or es e consequence of) Examiner Henathis B Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that inflieted events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es a consaquance of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy No 1 Yes 20 No 1 ☐ Yes 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Inpatient 2 ER/Outpetient 3 DOA 27. Menger of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation Maturel

or Attending Physician: The law requires that the death certificate be executed bunial-tran pue physician s the burial P.O. Box 68760, signed by the a Division of Vital Records. this After after death. the in by

28a-f show

ö

items 23a

Baltimore, Maryland 21215-0020

29a, Certifier

edical

State

Registrar

2 Accident

3 ☐ Suicide

4 - Homleide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the ceuse(s) end menner es steted.

| Medicel Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated.

1 ☐ Yes 2 ☐ No

29b. Signature and title of certifie MD 29c. Licansa number 29d. Date signed (Month, Dey, Year)

Baltimore MD

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print) Cha Johns Hopkins Hospital.

31. Dete filed (Month, Day, Year,

JAN 28 1998

6 Could not be determined

32. Ragintrade Signature wie Davidson

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

June Mill Hill Reduced to making a fit with a profession has been

State of Maryland / Department of Health and Mental Hygiene

Ite	em :		cate of Death Reg. No.	2077			
Physici /Medic	al	1. Decedent's Neme (First, Middle, Last) ELSIE MARIE WIBEL 4e. Fecility Neme (If not institution, give street end number)	2. Date of Death Month Dey Yeer JANUARY 26, 1998 4b. City, Town, or Location of Deeth 4c. County of Deeth	3. Time of Death 4:12 am			
Funeral Director	ier	GREATER BALTIMORE MEDICAL CENTE 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Iff (Mo) 039-28-79137193 1□ M 2☑F 85 Yrs.	R TOWSON BALTIMOR	E lece (State or Foreign try) N.Y.			
aryland show		Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location	10	0d. Inside City Limits			
ith the Maryland or 28s-f show	Directo	Md. Baltimore Baltimore 10e. Street end Number 10	f. Zip Code 10g. Citizen of Whet Count	1 ☐ Yes 2 ☑ No			
vithin 72 hours after deeth with the Maryland ene. 9ne. 11an "nefurel", or items 23a or 28a-f show the Medical Evaning must be notitled at	by Funeral Director		21210 USA **Tecedent of Hispenic Origin? (Specify Yes or Nospecify Cuban, Mexican, Puerto Rican, etc.)* as 2 No Specify: Specify: Whit	etc.			
TO THE	To Be Completed	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) 3 Nurse	Usuel Occupetion of work done during most of working OT use retired) Nursing				
be file tal Hy d oth		17. Fether's Neme (First, Middle, Last) Herbert Sprague O'Donnell	18. Mother's Name (First, Middle, Maiden Surname)	ctin			
Maryla nd 2 should lith and Men 27 Is merke r treumetic		19e. Informent's Name/Reletionship (Type, Print) daughter Mrs. Margaret W. Sickingen-Hohenburg 66	dress (Street end Number or Rural Route Number, City or Town, Stete, Zip	Code)			
Baltimore, semit. Pages 1 er Depertment of Hea mportant: If Item; iny injury or other once.		20a. Method of Disposition 1 ☐ Buriel 2 IX Cremation 3 ☐ Removel from Stete	(Name of or other place) Dete 20c. Location - City or Tow	wn, Stete			
Baltimore, M permit, Pages 1 and 2 Department of Health is important: If item 27 item 2 any injury or other tre		21. Signature of Funeral Service Licensee 22. Nar Ruck	vice Corp. 1/27/98 Towson, Md. eend Address of Fecility Towson Funeral Home, Inc. York Rd. Towson, Md. 21204	, Inc.			
Physician /Medical Examiner		23e. Pent 1. Enter the disease, or complications that caused the death Do not enter the shock, or heart feilure. List only one ceuse on each line. Immediate Ceuse (Finel disease or condition resulting in death) Due to (or es e consequence)		Approximate intervel Between Onset end Death			
Box 68760, death certificate be executed e ettending physician end of for use es the burial-trensit	Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last b. Due to (or es e consequence cause). Due to (or es e consequence cause). Due to (or es e consequence cause).					
Bert to O	Physician	Pert II. Other significant conditions contributing to deeth but not resulting in the underly	1 Yes 2 No 3 Prob				
Cords	Completed by Physician/M	from chole cystectory, phemos	performed? eve	ore eutopsy findings pilable prior to appletion of cause deeth?			
_ F # d	e Com	25. Wes case referred to medical		Yes 2 No			
ng Ph ng Ph fter thi	edical Certification: To B	exeminer? 1 Yes 2 No Hospital: 1 Impatient 2 EP/Outpetient 30 27. Menner of Death 1 Naturel 5 Pending 2 Accident Investigation Hospital: 1 Impatient 2 EP/Outpetient 30 28e. Dete of Injury (Month, Dey Year) Month	26. Place of Deeth (Check only one) DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify, Vork? 28c. Injury et Work? 1 Yes 2 No)			
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 4 Romicide 4 Romicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Pleca of Injury - At home, farm, street, factory, office City or Town, Stete)					
he Hospi in 24 hou he Funer pletely fil		29e. Certifier (Check only one) 1 **Certifying Physicien: To the best of my knowledge, death occurrence of the control of the properties	rred et the time, dete end place, end due to the ceuse(s) end menner es ste stion, in my opinion, deeth occurred et the time, date end place, end due to	eted. the cause(s)			
Tot With	X	29b. Signeture end title of certifier	29c. License number 29d. Date signed (<i>Month</i> , D	_			
(0)		30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)	Rd Towson MD 21204				
Sta Registr		31. Dete filed (Month, Day, Year) 32. Figurer's Signature And 9 8 1008	•				

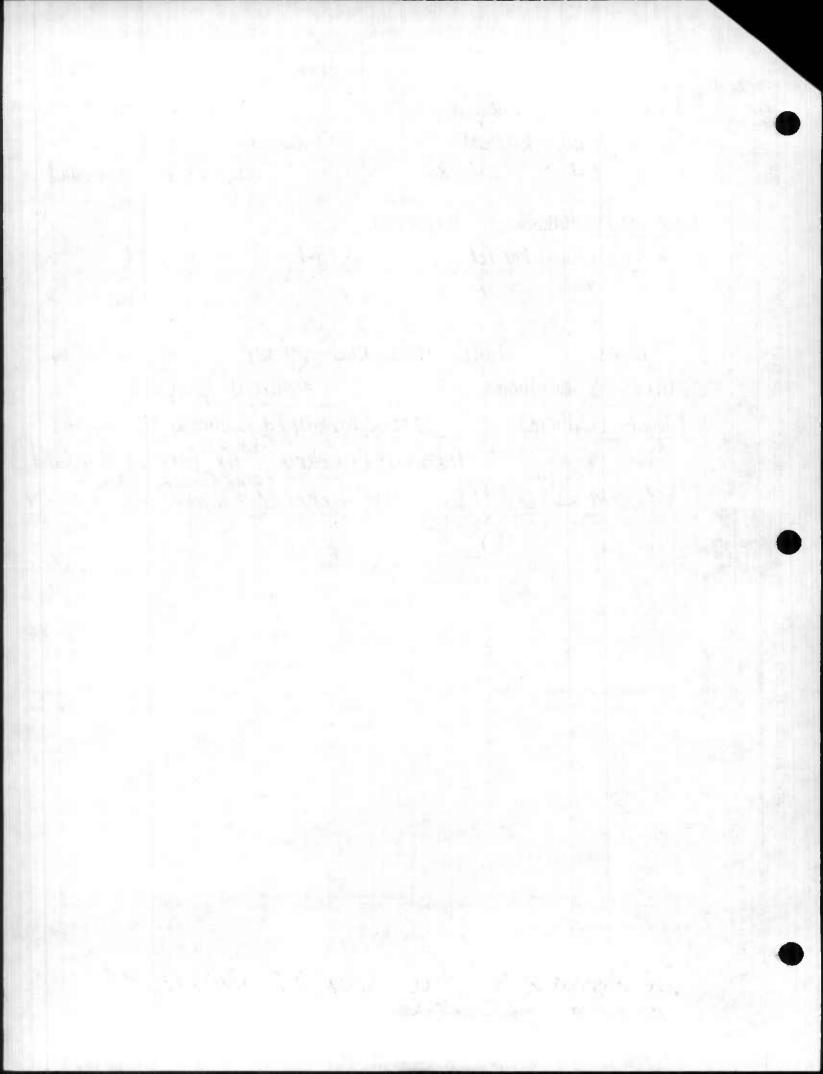
THE THE DECEMBER OF THE PARTY O

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Daath 3. Time of Deeth Month Physician /Medical Kinuaeu 4e. Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Deeth OUSON If Undar 24 Hrs. 5. Social Sacurity Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Yeer 8. Date of Birth Month, Dey 9. Birthpleca Funeral (Steta or Fpreign 1 Ø M 2 □ F Months Days Hours Min Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours eftar death with the Maryland 10a. State 10b. County show 10c. City, Town or Location 10d. Insida City Limits If item 27 is marked other than "natural", or items 23s or 28s-f sho or other traumstic event, the Macical Examinar must be notified at SHMORE Funeral Director Maryland 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Evar in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Dacedent of Hispenic Orlgin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Raca - American Indien Black, White, etc. 11. Maritel Status 1 Never Merried 2 Married 21215-0020 1 ☐ Yas 2 💢 No Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) nd Mantal Hygiene. marked other than Baltimore, Maryland 17. Fathar's Name (First, Middla, Last) 18. Mg er's Name (First, Middle, Maiden Sumeme) Be Department of Health end Mental Important: If Item 27 is marked or any injury or other traumatic eve 0 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21234 Mams Data 7 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 1 ⊠Buriel 2 □ Cremation 3 □ Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) permit. 21. Signature of Funeral Sarvice Licensee 22. Name end Address of Facility land21234 Enter the disease, or complications that caused the death, or heert feilure. List only ona ceuse on eech line. Do not entar tha mode of dylng, such as cerdiac or respiretory errest, Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events rasulting in deeth) Last and the buriel-trar Division of Vital Records, P.O. Box 68760. ed by the attending physician detached for use as the burie Physician/Medical use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? is certificate hes been signed by director, page 2 should be detac 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Tes 24 No 1 ☐ Yes 2 No or Attending Physician: 25. Was case refarred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours efter deeth. To the Funeral Director: After this 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending investigation 2 Accident 1 Yes 2 No completely filled in by the 6 Could not ba determined 3 Suicide 28e. Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 - Homlcide Hospital 1x Certifying Physician: To the bast of my knowledge, death occurred et the time, data and pleca, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and manner stated. edicai 29a. Certifiar (Check only one) ş 29d. Date signed (Month, Dey, Yeer) 29b. Signature end title of 0 30. Name and address 31. Dete filed (Month, Day, State 28 1998

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'e Neme (First, Middle, Last) 2. Dele of Death 3. Time of Death Dev **Physician** Wilson JAN /Medical 4c. County of Death 4e. Fecility Neme (If not Institution, give str 4b. City, Town, or Location of Death **Examiner** Itimor If Under Months Under 24 Hrs. 5. Social Security Number 7. Age (In-yrs. last birthdey) 9. Birthplece (State or Foreign Country) **Funeral** Deys Hours Ma 70 212-22-7608 Director Usuet Residence of Decedent with the Meryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City I Imits or 28a-f show other treumstic event, the Medical Examiner must be notified at Baltimore Kandallstown 1 ☐ Yes 2 XNo Md Director 10e. Street and Number 10g. Citizen of Whet Country? "natural", or items 23s 21208 4705 uncannon Funeral 12. Wes Decedent Ever in U.S.
Armed Forces?
1 Days 2 No 1-9-45
1/4 Yes, Give
Yeer or Detes: \$-10-48 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11. Meritel Status permit. Pages 1 end 2 should be filed within 72 hours effer. Depertment of Health and Mental Hygiena. Important: if Item 27 is merked other than "natural", or Item any Injury or other treumatic event. The Medical Exempt 1 Never Married 2 Merrled Black 1 ☐ Yes 2 XNo by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grede completed) 18b. Kind of Business/Industry Company Moving Elementary/Secondary (0-12) College (1-4or 5+) Helper 12th grade 17. Fether's Neme (First, Middle, Last) 185 Mother's Neme (First, Middle, Maiden Sumeme) Be ebbecca Samuel 2 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diggs ela 4705 21208 Saltimore, 20b. Pleca of Disposition (Name of cemetery, cremetory or other pleca) 20s. Mathod of Disposition Dete 20c. Location - City or Town, Stete 1 □ Juriei 2 □ Cremetion 3 □ Removei from Stete Donetion 5 Other (Specify) Garrison For Ver Signature of Funeral Service Licenses Balto, Hd 00 walash Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one ceuse on each line. Physician Immediate Causa (Final disease or condition resulting in deeth) Carcinoma i Metastasis to Brain /Medical Examiner Due to (or es e consequenca of): Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury linet initieted events resulting in deeth) Lest Due to (or es e consequenca of): 68768 Physician/Medical 94 Due to (or es e consequence of): The law requires that the death certificate Box P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown by Division of Vital Records, 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy periormed' After this certificate hes 1 Yes 2 No 1 Yes 2€ No To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this certifice 25. Wes cese referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitei: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 21 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3□ DOA funeral 27. Menner of Deeth Certification: 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describa how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident Couid not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide edicai 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) end manner stated.

Park 7220 31. Dete filed (Month, Dey, Year) State 28 1998 Registrar

29b. Signeture end little of cartifier

Avenue Heights 32. Registrer's Signature

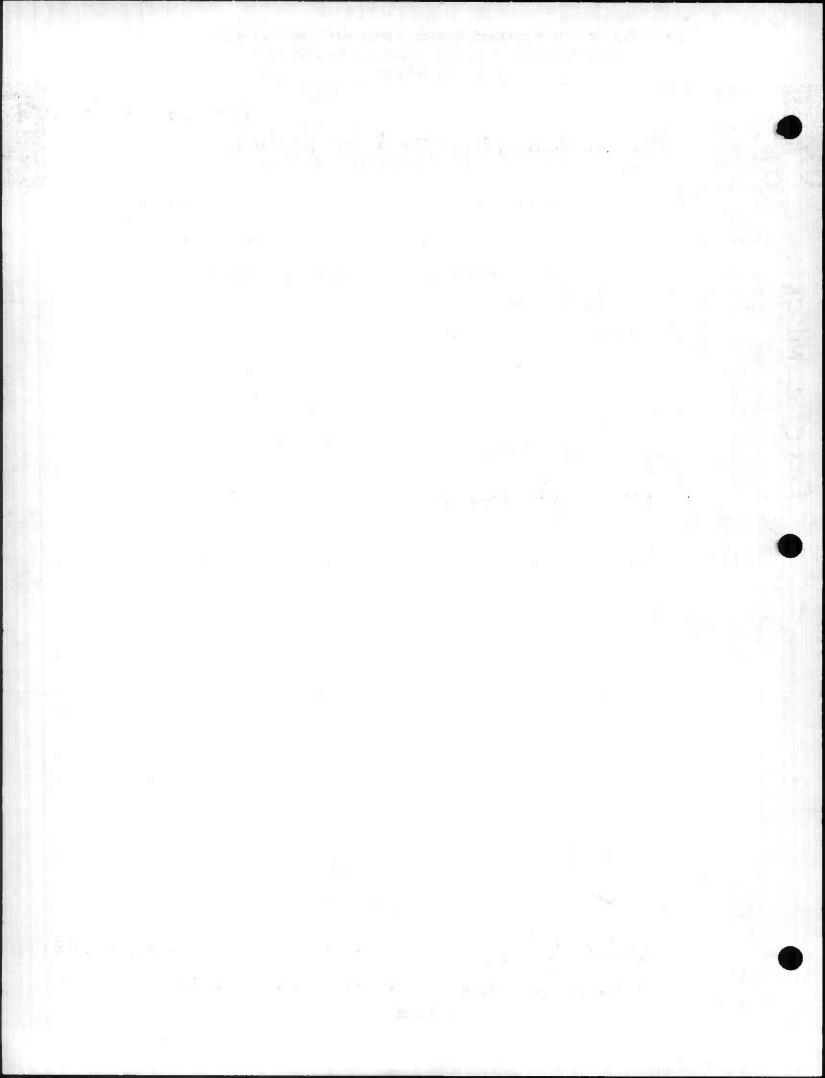
30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Baltimone Mis

29d. Date signed (Month, Dey, Year)

january 26, 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3 Time of Death Dey 26 :50 P. M Ivan Bennar White, Jr. Januar 4e. Fecility, Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Bumie Glen Aure Arende HOSpita Vorth Hrunde 5. Sociel Security Number If Under 1 Year if Under 24 Hrs. 8. Dete of Birth (Month, Day, Yea May 21, I 9. Birthplace (State or Foreign County) Mary land 7. Age (In yrs. lest birthdey) Months Deys Hours 1√ M 2 F 214-38-0077 55 Yrs Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Glen Burnie 1 Yes ZONo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1591 Dulanev Lane 21060 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) 11th Meat Manager Giant Food 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Ivan Bennar White, Sr. Viola Marie Short 19e. Intorment's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Carol White (Wife) 1591 Dulaney Lane Glen Burnie, Maryland 21060 20e. Method ot Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete N☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Glen Haven Memorial Park 1/30/98 Glen Burnie, Maryland 21. Seture of Funeral Service Licensee Kevin E. McCully-Polyniak Funeral Home 237 E. Patapsco Avenue Balto., Md. 21225 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart teilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in deeth) DISEASE Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence ot) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were eutopsy tindings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2 No 2 No 25. Wes case reterred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Yes 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manyler of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Neturel 5 Pending 1 Yes 2 No investigation 2 Accident

Examiner The law requires that the death certificete be executed P.O. Box 68760. Records, Division of Vital

Examiner physician and the buriel-transit Physician/Medical use as for use as signed t by icate has been sign, pege 2 should b Be Completed certificate director, Certification: To this funeral After

Physician

/Medical

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Md.

Director

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r is merked other than "natural", or items 23s or 28s-f shor traumatic event, the Medical Examiner mast be notified at

filed within 72 hours aftar of Hygiena.

1 end 2 should be f Health end Mental I

permit. Pages 1 end 2
Department of Health e
Important: if itam 27 is
any injury or other tra
once.

Physician /Medicai

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: All complately filled in by the fu

> State Registrar

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Medical

31. Defe filed (Month, Dey, Year)

29b. Signeture end title of certities

3 ☐ Suicide

29a, Certifier

4 - Homicide

(Check only one)

6 Could not be determined

Mymil

2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. License number 29d. Dete signed (Month, Dey, Year)

V Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

28t. Location (Street end Number or Rural Route Number, City or Town, State)

30 Neme end eddress of person who completed cause ot deeth (item 23e) (Type, Print) Brive

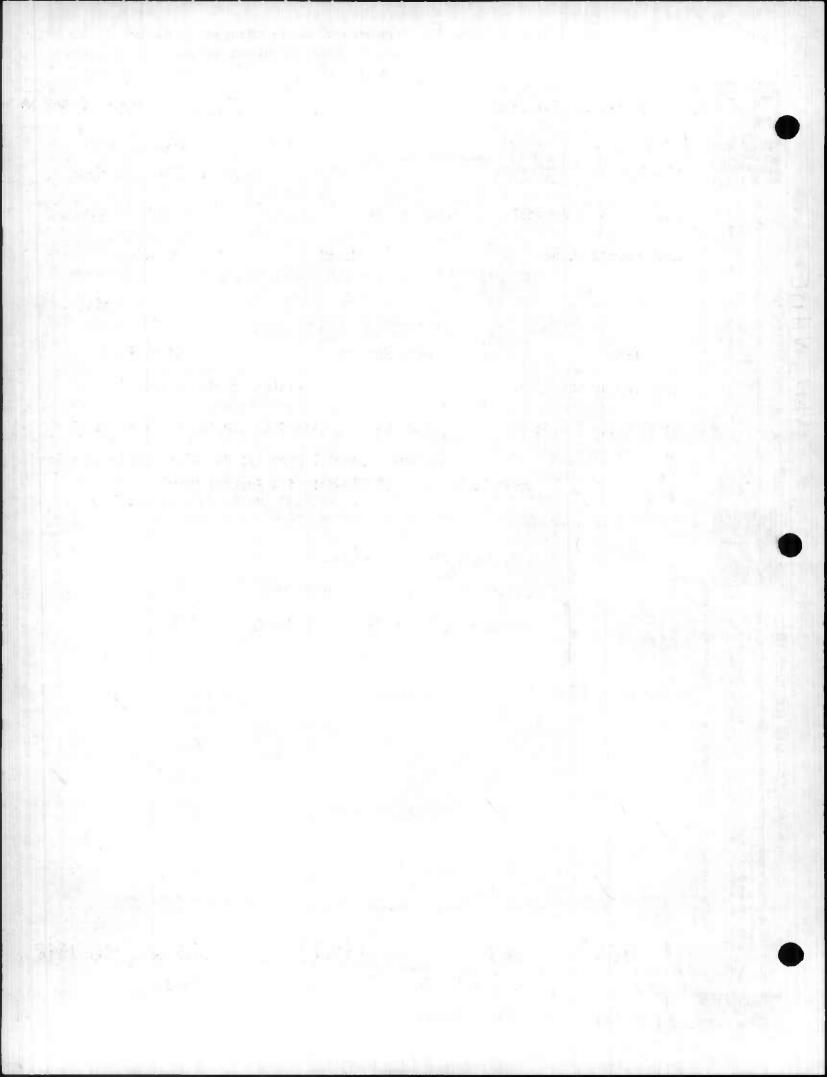
301 from L 32. Registrar's Signeture Julie Sandson Randall

MD

28e. Plece of Injury - At home, ferm, street, tactory, office building, etc. (Specify)

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death 2. Dete of Deeth Month Estella wiegate 8:37 pm 1998 25 Jan 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore Memorial Hospital Hours Min. 8. Dete of Birth (Month, Day, DEC 27, If Under 1 Yaar 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign 1□M 2EXF Deys 213-16-3854 94 MARYLAND Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 □ No MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2095 ROCK ROSE AVENUE 21211

13. Was Decedant of Hispenic Origin? (Specify Yas or NoIf Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - American Indien, Black, Whita, atc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Yaar or Datas: 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE 15. Decedant's Education (Specify only highest grade completed) 16e. Decedant's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Coilage (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumems) WILLIAM KRAMER BESSIE PANOVVITZ 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) GRACE C. BROCATO, NIECE 311 STRATFORD ROAD, CATONSVILLE, MARYLAND 21228 20b. Plece of Disposition (Name of camatery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Ramoval from Stete GARDENS OF FAITH 1/28/98 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme and Address of Facility 21. Signetura of Funerel Service Licensae WITZKE FUNERAL HOMES, INC. Lemmer 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth immediate Ceusa (Final Arres + Cardiopulmonar diseese or condition rasulting in death) Dua to (or es a consequence of): weeks neumunia Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaese or injury that initieted events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementia 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24e. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes cese raferred to medical 26. Place of Death (Check only one) Hospitei: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury et Work? 27. Mennar of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Invastigetion 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident

P.O. Box 68760, Division of Vital Records.

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at

pernit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiena. Important: If Item 27 is marked other than any injury or other traumatic event, the Manan Injury Inj

Physician /Medical

Examiner

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After this certificate

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Certification:

3 ☐ Suicide

29a. Certifier

4 Homicide

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death v

be filed within 72 hours efter

Baltimore, Maryland 21215-0020

Attending

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo Medical

State Registrar

1 Certifying Physician: To the best of my knowledge, daeth occurred et the time, dete end piece, end due to tha causa(s) and mannar as stated.

2 Madical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred et the time, date end piace, and due to the cause(s) end mannar stated. 29b. Signature and title of certiful M. D. ing

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number 29d. Deta signed (Month, Dey, Year) 038026

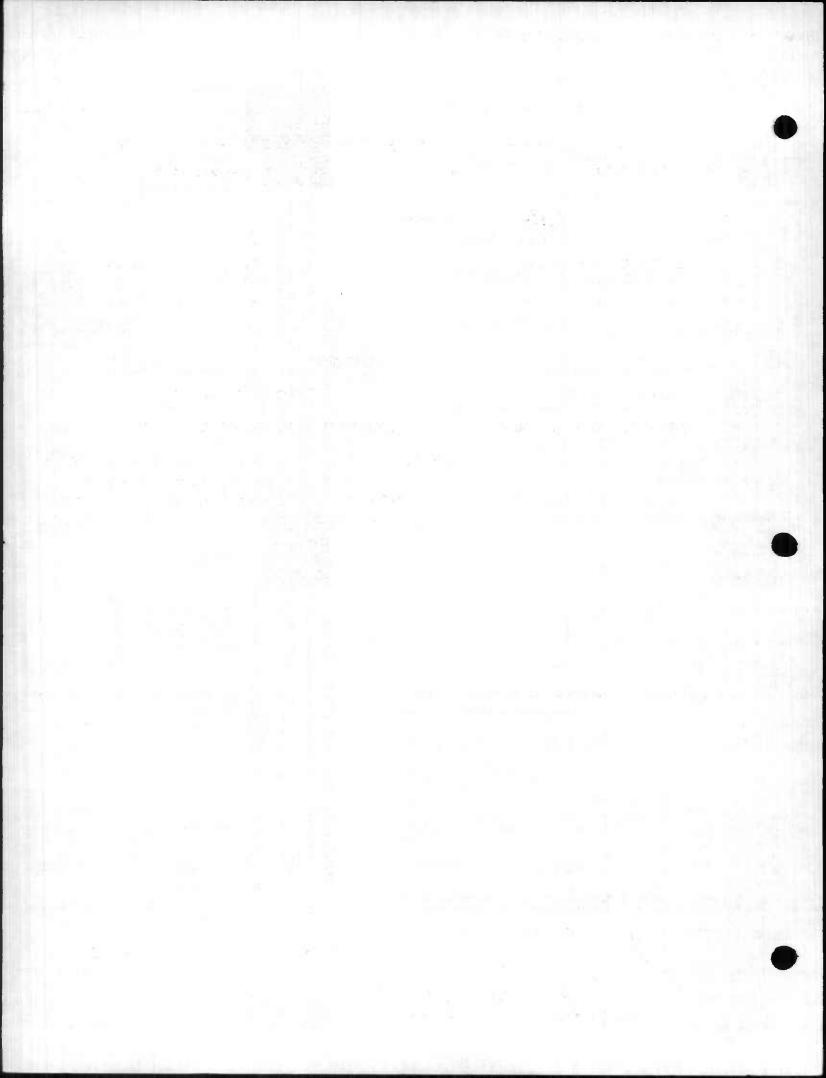
28f. Location (Street end Number or Rural Routa Number, City or Town, State)

30. Nema and address of person who complated cause of daeth (Itam 23a) (Type, Print)

6 Could not be

Mar king E. University Pkny Emergency 201 31. Dete filed (Month, Day, Year)

28 1998



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Veer Samuel E. Wagner 20, 1998 4c. County of Deeth /Medical JANUARY 0955 AM 4a. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth Examiner Sacred Heart Hospital **Alleghany** Cumberland 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Yes 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funerai** Days 1**⊠** M 2□ F 83 Yrs 1914 Pennsylvania Director 040-18-1954 Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director unknown Pennsylvania Bedford 10e. Street and Number 10f. Zip Code 10a, Citizen of Whet Country? 6 212 North Richard Street 15522 U.S.A. items 23a Funeral filed within 72 hours after death Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indien, Bleck, White, etc. 1 X Yes 2 ☐ No if Yes, Give Yeer or Dates: 1 Never Married 2 Married 21215-0020 6 1 Yes 2 No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown Guard Prison Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be fill ment of Health and Mentel Hi tant: If Item 27 Is marked oth Be Clyde Everal Wagner, Sr. Mary May Downing 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 s Depertment of Health an important: if item 27 is any injury or other trau once. 553 Friendship Village, Bedford, Pennsylvania15522 of Disposition (Name of Date 20c. Location - City or Town, State Virginia Wilkinson/sister Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S 22. Neme end Address of Facility
State Anatomy Board, 655 W. Baltimore Street Director Wade MI Baltimore, Maryland 21201 3e. Peril. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shork, or heer tailure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical . MYO CARDIAL IN FARCTIOIN 75 min immediat Ceuse (Final disease or condition resulting in death) Examiner ALTELIUS CLEED TIC CARDIN JASCULAR DIFEASE Examiner The law requires that the death certificete be executed buriel-transi Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest end Box 68760. physician Physician/Medicai Due to (or as e consequence ot) been signed by the should be deteched it Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. P.O. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 0 v/muray 6,150651 Division of Vital Records. þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Was en eutopsy performed? 2 1 No this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p. 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Menger of Deeth 28a. Date of Injury (Month, Day Year) Certification: 28h Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, tactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner es steted.

2 Medicat Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted. Medical 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 20 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

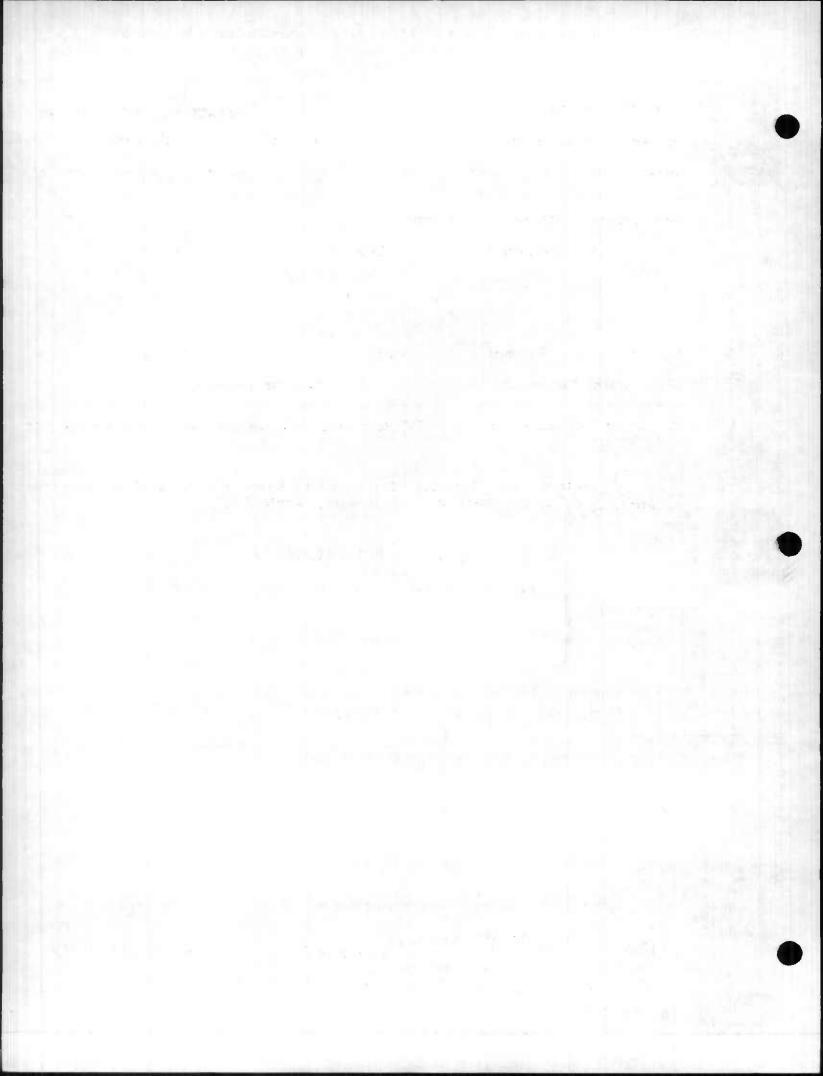
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State Registrar 31. Dete filed (Month, Day, Year)

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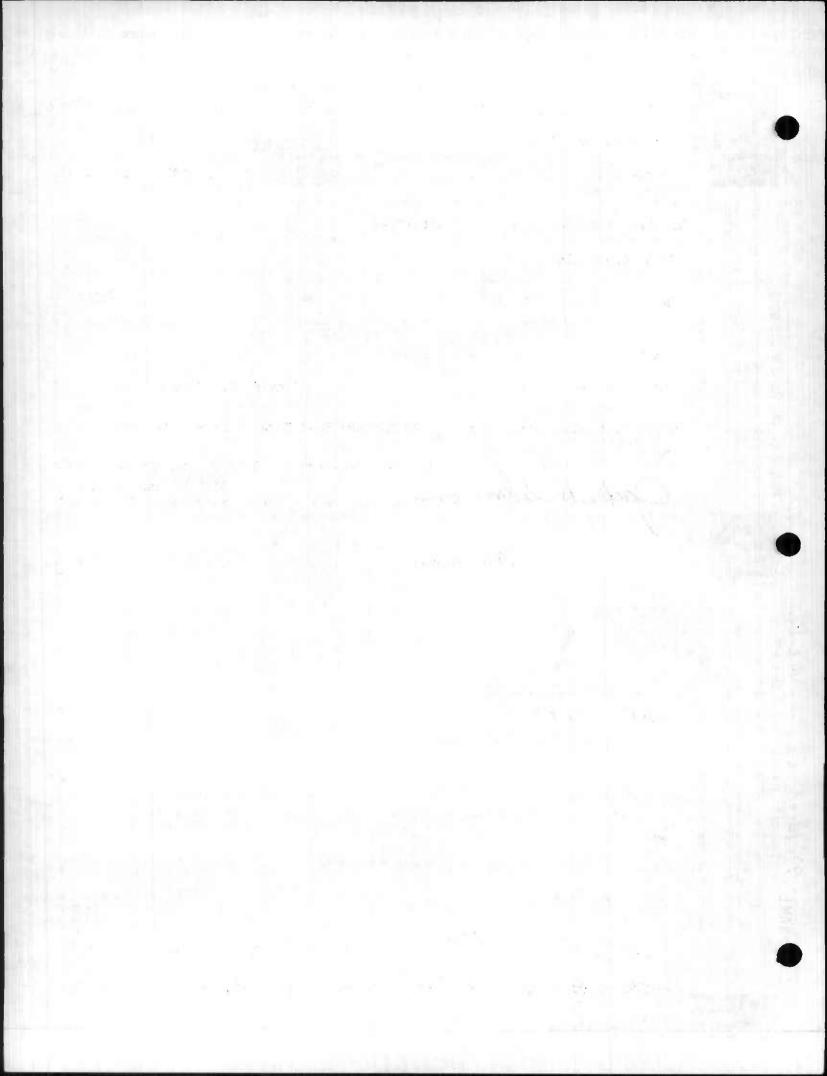
32 Registrar's Signature

Suna Naydoon—Aandall



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Physi		MILDRED OLIVIA WEIBE	Month			10:25 Am.				
/Med Exam			JAN 23 1998 Location of Death 4c. County of Death			[[[]]]				
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Baltimore, semit. Pages 1 an Department of Hea moortant: if then 2		20a, Method of Disposition 20b, Place of Disposition (Neme of	Date	20c. Location						
MO Page		todeurial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify)	1 /26 /05	D-1-4-		Manual and				
permit. Pages 1 and 2 Department of Health a Important: if them 27 is any injury or other tra		21. Signature of Funeral Service Licensee // Loudon Park Cemetery 22. Name and Address of Facility				Maryland				
Department	8	Jacke W. Skonnon	ns Avenue MD 21229							
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.⊆ Ø ₽			24a. W	24a. Wes an eutopsy performed? 24b. Were autopsy findin available prior to						
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To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral	N N	29h Signature and title of cartifier 29c. License number		29d. Date sign	ed (Month,	Dey, Yeer)				
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9		30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) Haytham Bishara St Agnes Hospital 950 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Cotan 1	No Box	4	M127177				
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	WOUT !	IFC , JULIE	PEIOR	· He lable				
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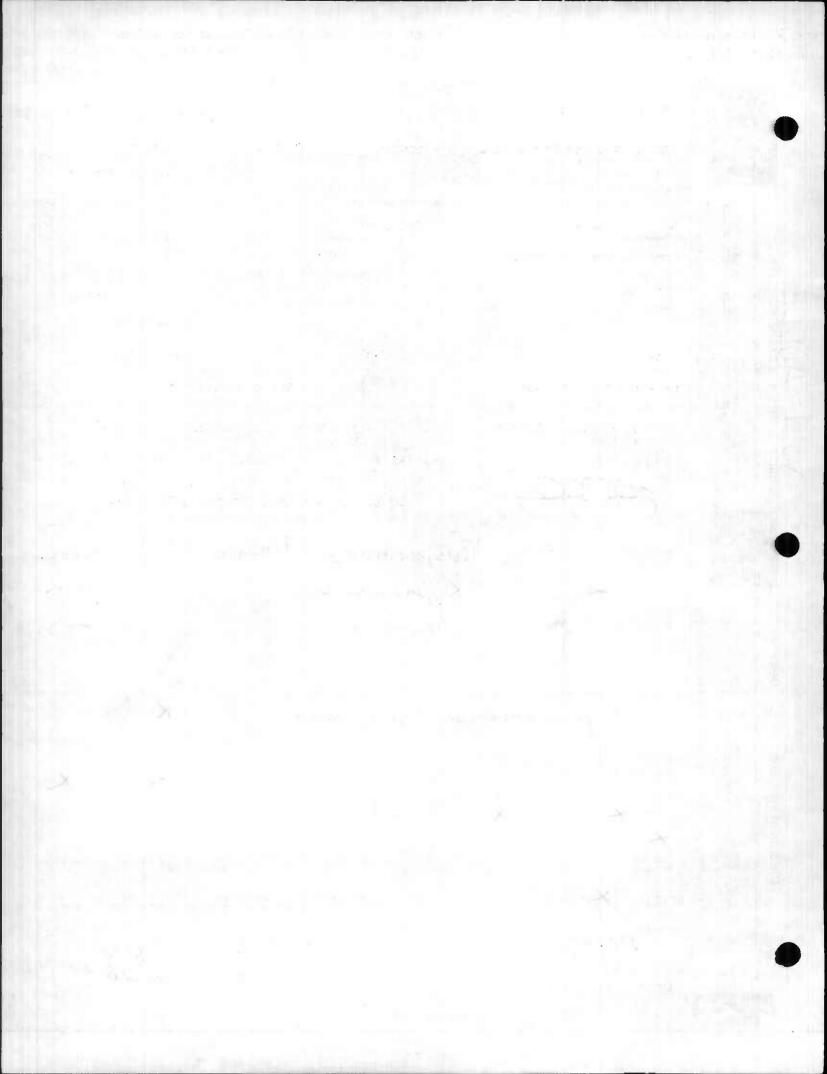


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Deeth 3. Tima of Death **Physician** Adele Dorothy Yost 02:40 AM 4b. City, Town, or Location of Death 23,1998 4c. County of Death /Medical 4a. Fecility Nama (If not institution, giva street and number) Examiner Hours Min. 8. Dete of Birth 9. Birthplace (State Country)
Mar. 17, 1919 Baltimore, MD GREATER BALTIMORE MEDICAL CENTER
5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Frunder 1 Year BALTIMORE

9. Birthplace (State or Foraign Country) **Funeral** Days Months 1 M 2 F 78 212-22-4282 Director Usual Rasidance of Decedant 10a. Stata 10c, City, Town or Location 10b. County 10d. Insida City Limits 1☐ Yes 2☐ No Director Baltimore Cockeysville 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? ms 23a or must be r 21030 USA Masonic Home of Maryland Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2% No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, 11 Maritel Status Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) Black, Whita, etc. 1€Naver Married 2 Married White 'natural', or 1 ☐ Yes 2 No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hygiene Bookkeeper Insurance 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Be Pages 1 and 2 should be Mental George Steedman Yost Adele Dantemeyer 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 2 Item 27 247C Rodgers Forge Rd., Baltimore, MD 21212 Anne Y. Carney - Sister Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other placa) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete ъ Important: If It any injury or o once. 1 Burial 2 Cramation 3 Ramoval from Stata Jan. 26, 1998 Pikesville, MD 4 ☐ Donetion 5 ☐ Othar (Spacify) Druid Ridge 21. Signetura of Funeral S 22. Nama end Addrass of Facility Lemmon Funeral Home Michael 10 W. Padonia Rd., Timonium, MD 21093 23a. Perit. Entar tha disease or complications thet caused the death. Do not enter tha moda of dying, such as cardiac or raspiretory errest, shock, or haart failura. List only ona causa on each lina. Approximate Intarval Batween Onset and Daath **Physician** FAILURE Immedieta Ceusa (Final disaasa or condition resulting in deeth) /Medical (PSPIRATORY Weeks Examiner Dua to (or as a consequance of): Examiner PHOSCOLIOSIS physician and the buriel-trensit The law requires that the death certificate be executed Sequantially list conditions, if eny, leading to immadiata cause. Enter Undarfying Cause (Disaasa or Injury that initiated avants rasulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, neumonia Physician/Medical Due to (or es e consequance of): signed by the a d be detached 1 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Supraver Tricular TACHY CARDIN þ 24b. Wara eutopsy findings eveileble prior to complation of causa of daath? 24a. Was an autopsy performad? Completed hes certificate he lirector, page 2 1 Yes 2 No 1 ☐ Yas X No Attending Physician: 25. Was cesa raferrad to medical axaminer? Be 26. Placa of Death (Check only ona) Hospitel: 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Spacify) 10 1 Yas 2 100 this 28b. Time of 27. Mannar of Death 28d. Describe how Injury occurred 28a. Deta of Injury (Month, Dey Year) 28c. Injury et Work? Certification: After 1 Matural 5 Pending 1 Yas 2 No Hospital or Attendir 24 hours efter death. Funeral Director: A sletely filled in by the fu death. 2 Accidant Invastigation 6 Could not be datarminad 3 ☐ Suicida 28f. Location (Straat end Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At home, farm, straat, factory, offica building, atc. (Spacify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar edical (Check only one) To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier 11 5 1362 1/29/98 York Ad 32c buttentle 30. Name and eddrass of person who complated causa of daath (Item 23a) (Type, Print) SUZAFIS 1205 (Month, Day, Year) N 28 1998 32. Ragistrar's Signature State

una Davidson-Randale

Registrar



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Completed

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Certification:

Medical

Division of Vital Records. irector, page 2 Attending Physician: funeral director. this After

Other: 4 Nursing Home 5 Residence SCOTHER (Specify) AT SCENE 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. injury et Work? 5 Pending investigation Injury 1/25/98 Could not be

unknown 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) found in house

1 Yes 2 (No

29c. License number

O.C.M.E

26. Plece of Deeth (Check only one)

unknown 28f. Location (Street end Number or Rural Route Number, City or Town, State 404 S. Bentalou St.,

29d. Date signed (Month, Dey, Yeer)

26, 1998

2 No

0907 AM

1 Yes 2 □ No

Baltimore, Md. 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

JAN.

2 No

28d. Describe how Injury occurred

Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Locke 111 Penn Street, Baltimore, Maryland 21201 KON

State Registrar

31. Dete filed (Month, Day, Year) 28

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25. Wes case referred to medical

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27. Manner of Deeth

1 Neturel

2 Accident

3 Suicide

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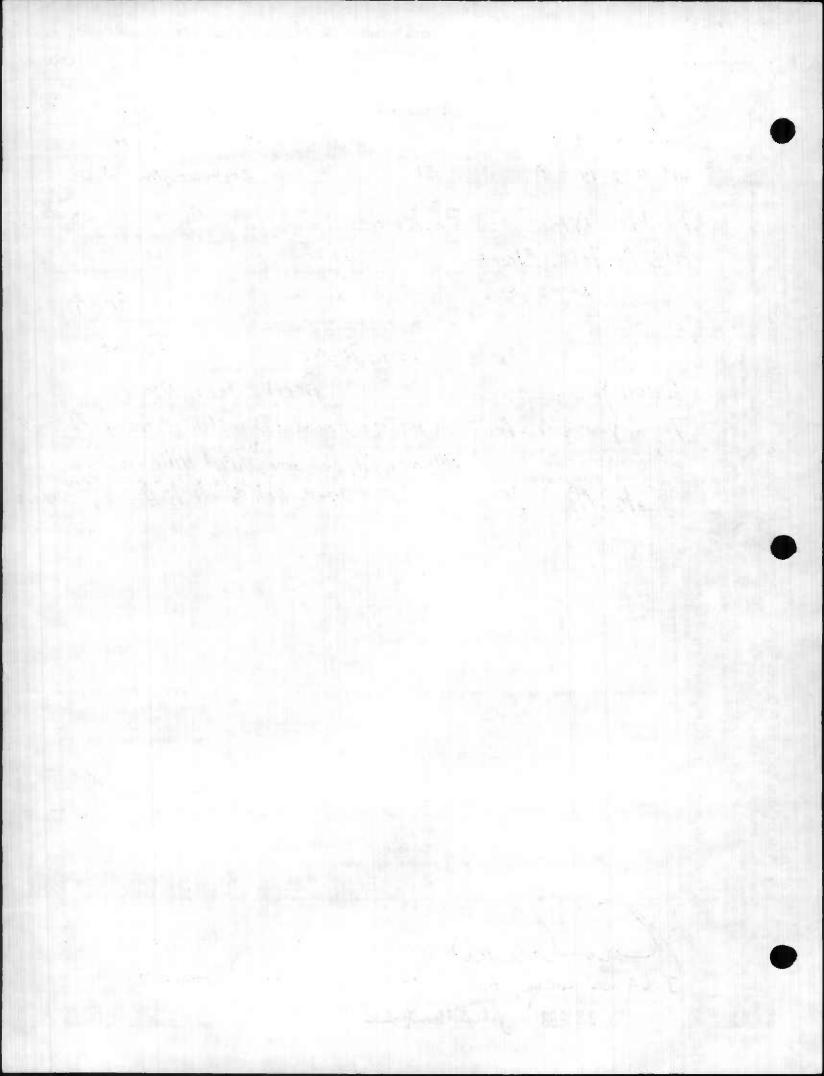
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To the



State of Maryland / Department of Health and Mental Hygiene 9 8 12086

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Director		Anne Arundel Medical Center						polis			e Aru	
28a-f show offined at		5. Social Sacurity Number 6. S 214-74-1238 Usual Rasidance of Dacedent	Sex I□ M ŽQXF	90	Yrs. Monti	der 1 Yea ns Day		Min.	8. Date of Birth (Month, Day) Feb 25	, Year) 1907		ng ton, I
28a-f sh offfind		10a. State 10b. County		10c. City, Town	n or Location						10	d. Inside City L
28	to	MD Anne Ar	undel	Ar	nnapoli	S						XXYes 2
1.5	Director	10e. Street end Number			10f.	Zip Code	y T		1	0g. Citizan of \	What Count	ry?
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jiena. r than "natural", or flame 23e or 28e-f show the Medical Examinet must be notified at	by Funeral	11. Maritel Stetus 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 Yas 2 N If Yas, Give Yaar or Datas:			cedant of pecify Cu		gin? (Spec n, Puarto F	cify Yes or No- Rican, etc.)	Bie	ea - Amarica ck, Whita, e	tc.
atom		15. Dacedant's Ed	ducation	16a.	Decedant's U	sual Occi	upation			16b. Kind of B	usinass/Inde	stry
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t of Health If Item 27 or other to	-	John Adair, Jr.	(Son)		TU Dalk f Disposition (i							
Depertment of Health Important: If Item 27 any Injury or other tr once.		20a. Mathod of Disposition 1 XXurlel 2 ☐ Cremation 3 ☐ Donation 5 ☐ Other (Specification)		cemeter	ry, cremetory of 1 State	s Na	val Ac		y Cemet		napoli	s,Maryl
Department Important: the any injury of once.	9	21. Signature of Funeral Service Lice	Jus Ton	/	147	Duke	of Gl	ouce	M. Tay ster St	. Anna	neral apolis	Home, I
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Medical and physician and street street stree	Examiner	Immediate Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any leading to immediate	b	Dua to (or es a c	consequanca	of):	[7]	CAR	-1 1	MILW		6 WE
		Sequantially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Disaasa or injury that initiated events rasulting in death) Lest Due to (or es a consequence of): Due to (or es e consequenca of): d.										
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within 2 To the complet	8 M	one) and mannar stated.							29d. Data signed (Month, Day, Year)			
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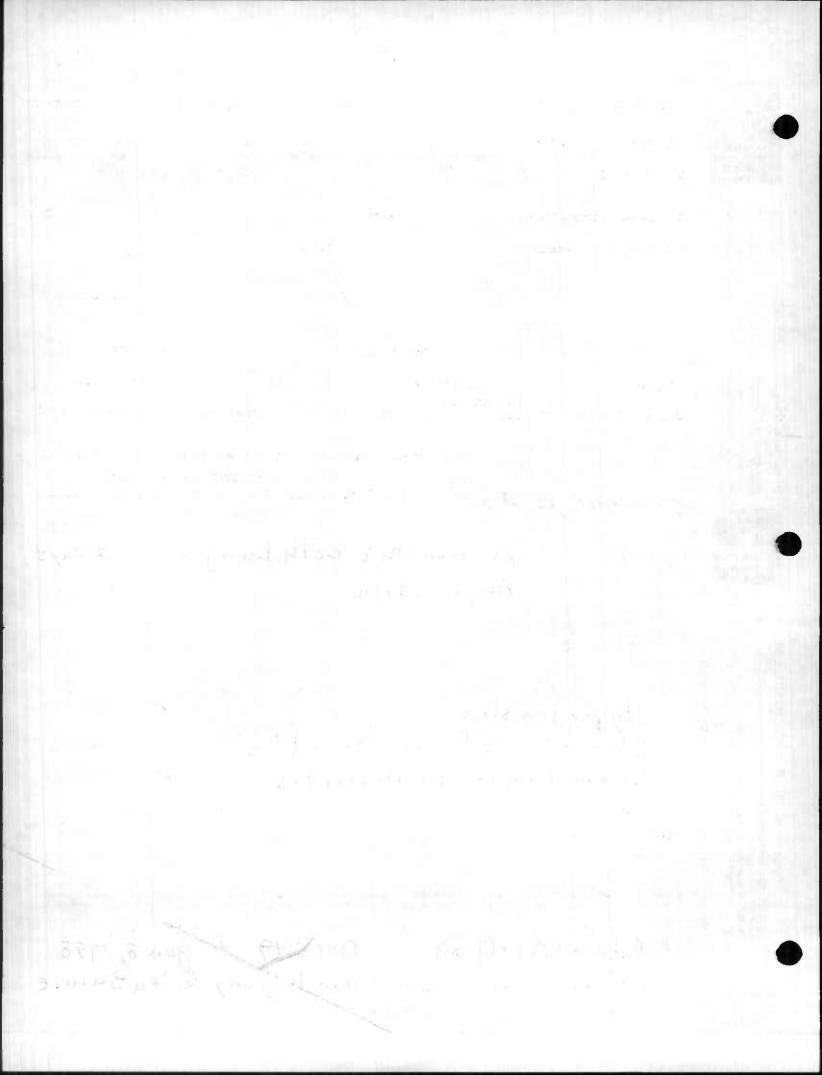
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Dacedant's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** JANUARY 8, 1998 KATHERINE **JEANNETTE** BOLL 12:05 AM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Daath Examiner Anne Arundel Glen Burnie 309 Mary Lou Avenue If Under 1 Year If Under 24 Hrs. 5. Social Sacurity Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
Sept. 30, 1903 Maryland 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Deys 94 Yrs. Director 215-07-2925 permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mantal Hygiene. Important: if Item 27 Is marked other than "natural", or Items 23s --- any injury or other traumatic event. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Glen Burnie 1 Yas 2 No Anne Arundel Funeral Director Maryland 10e. Street and Numbar 10f. Zip Code 10g. Citizan of What Country? 21060 309 Mary Lou Avenue U.S.A. 12. Was Dacedant Ever In U,S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) Race - Amaricen Indian, Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Marriad 1 ☐ Yas 2 ☐ No Specify: White þ 3 Widowad 4 □ Divorced Completed 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) N/A Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be Westenhofer Haegerich Helen 19e. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Mary Lou Avenue, Glen Burnie, Maryland Dorothy Marlene Carrick 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 □ Cramation 3 □ Ramoval from Stata Glen Haven Memorial Park 1/12/98Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 chael 23a. Part1. Enter the disease, or complications that deused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in daath) Examiner Examiner 100 The law requires that the death certificate be executed burial-transit Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Diseasa or injury that initiated events rasulting in death) Last end Due to (or as a consequence of) P.O. Box 68760. ettending physician for use es the buria Physician/Medical Due to (or as a consequenca of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. ate hes been signed by the page 2 should be detached 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown Hypertension Division of Vital Records, þ 24b. Wara autopsy findings availabla prior to completion of ceuse of deeth? Chronic Stasis Completed 24a. Was an autopsy performed? this certificate hes Severe Degenerative Arthrit 1 ☐ Yas 2 ☐ No or Attending Physician: director, Be 25. Was casa rafarred to medical axaminer? 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Home 5 Ansidence 6 Othar (Specify) 1 Yas 2 No 10 nours efter death.

neral Director: After this in y filled in by the funeral director. 28a. Deta of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Certification: 5 Pending invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datermined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, straat, factory, office building, atc. (Specify) 4 Homicide within 24 hours e To the Funeral C 1 Fertifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end mennar stated. edicai 29a. Certifian (Check only one) 29b. Signeture end titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) arles 1600 Crain 31. Data filad (Month, Day, Year) 32. Registrar's Signature State JAN 1 3 1998 ulia Davidson Registrar



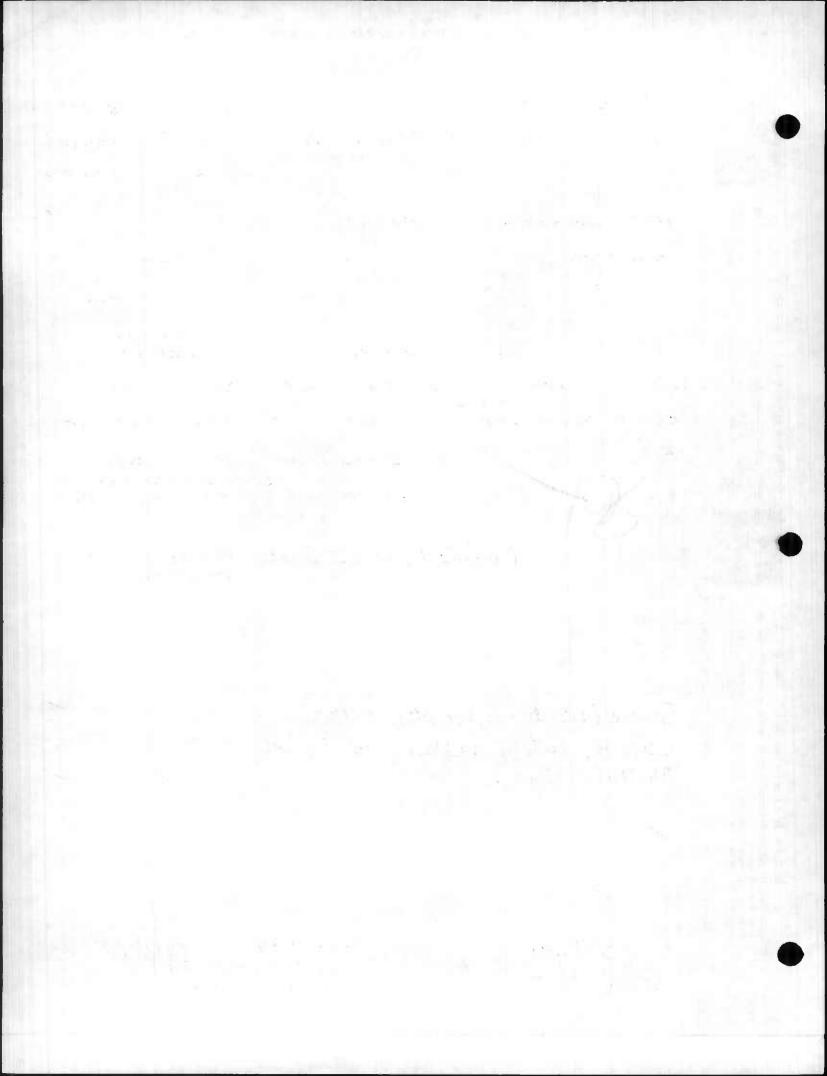
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month)awasa Bollinger 7:15 AM /Medical 4a. Fecility Nema (If not institution, giva street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Glan Bumia, Health of North Arunda ariner MD Anna Annal If Undar 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Dey, JULY 14 5. Social Security Number 9. Birthpleca (Stete or Foreign Country) 1927 PENNSYLVANIA 7. Age (In yrs. last birthday) **Funeral** 216-20-1975 70 Director Usual Residence of Decedent should be filed within 72 hours effer death with the Maryland nd Mentel Hygiene.

marked other than "natural", or items 23a or 28a-f show 10e State 10b County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner rout be notified at 1 Yas 2 No Director ANNE ARUNDEL MARYLAND GLEN BURNIE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1204 ASTER DRIVE 21061 Funeral U.S.A. 12. Was Decedant Evar in U.S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Detes: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: WHITE þ 3 Widowad 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) A.F.L.C.I.O. Elementary/Secondary (0-12) College (1-4or 5+) N/A MACHINEST DISTRICT 12 traumatic event, 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 end 2 should be 1 Department of Heelth end Mentel I Importent: If item 27 Ia merked of any Injury or other traumatic eve LEROY OSCAR BOLLINGER HAZEL MARIE WAITE 19e. Informent's Neme/Reletionship (Type, Print) (WIFE) 19b. Mailing Address (Straet and Number or Rurel Route Number, City or Town, Stete, Zip Code) EVELYN ELIZABETH BOLLINGER 1204 ASTER DRIVE, GLEN BURNIE, MARYLAND 21061 20b. Plece of Disposition (Name of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State IX Burial 2 ☐ Cremetion 3 ☐ Ramovel from Stete GLEN HAVEN MEMORIAL PARK 4 ☐ Donetion 5 ☐ Other (Specify) 1/10/98 GLEN BURNIE, MD. 22. Name and Address of Fecility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ily one cause on each line. Approximete Intervel Batwaen Onset end Deeth **Physician** onsequence of): Blead vs. Pulmonary
Hamorrhage /Medical Immediete Ceusa (Final disease or condition resulting in death) Examiner Examiner siclan end burial-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) physician s the burial Box 68760, Physician/Medical Dua to (or es e consequence of) 98 use signed by the el P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 B Unknown Records, by Be Completed page 2 should 24b. Were eutopsy findings eveilable prior to completion of causa of deeth? 24e. Wes en eutopsy performed? Muthole 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No After this certificate Division of Vital To the Hospital or Attanding Physician: within 24 hours effer deeth.

To the Funeral Director: Affer this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To 27. Manner of Deeth 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Maturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rurel Route Number, City or Town, State) 4 Homloide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

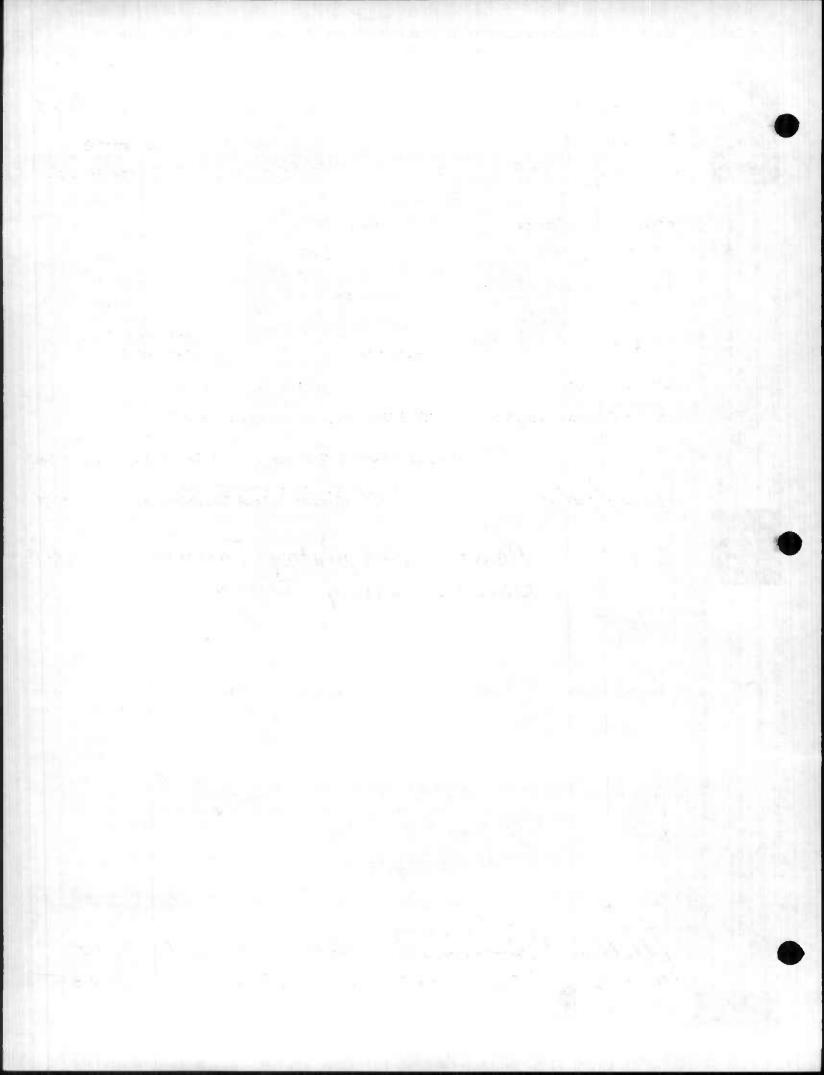
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. Medical 29e. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 52139 3048 Mitchellville Rd 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) Bowie, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State relia Davidson Registrar



State of Maryland / Department of Health and Mental Hygiene ?

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death **Physician** Month Janet H. Best January 12, 1998 /Medical 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3521 Shady Drive | Edgewater | If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea Anne Arundel 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** 1□ M 2♥ F 577-50-8504 Director 60 Yrs Washington, D.C. Usual Residence of Decedent the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director Edgewater Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? filed within 72 hours after death with 3521 Shady Drive 21037 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, atc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 Yes 2000 Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Wshington, D.C. Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Government Secretary marked other traumatic event. 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be Pagas 1 and 2 should be I James T. Gilner Helen C. Casserly 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ant of Health et: If Item 27 is yor other train Kathleen Johnson/Daughter 3522 Oak Dr., Edgewater, MD 21037 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or Lakemont Memorial Gardens 1/15/98 Davidsonvile, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md. 21037 art1. Entar the disease, or complications that caused tha death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disaase or condition resulting in death) Examiner Examiner hronic The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai Dua to (or as a consequence of): been signed by the attendin should be deteched for use Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. Division of Vital Records, P.O. 23b. Dfd tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown 1 Yes 2 No Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of causa of death? paga 2 hes 1 ☐ Yas 2 No cartificata 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was casa referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidenca 6 Other (Specify) 1 Yes 2 No Certification: To this funaral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Aftar Naturai 5 Pending investigation death. 1 Yes 2 No s after death 2 Accidant complately filled in by tha 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital
 24 hours a
 Funeral C 1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier Medical (Check only one) To the Vithin 2 29b. Signature and title of certified Deputy 06054 ime and address of person who completed cause of deeth (Item 23a) (Type, Print) enes, mo 31. Date filed (Month, Day, Year) JAN 15 1998 32. Registrar's Signature State his Davidson Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** PRISCILLA ANN BARSAM 4:30 8,m /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford If Under 1 Year if Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 200 Months Deys Yrs. Director 027-20-5951 May 28, 1927 Mass. Usual Residence of Decedent the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 √Yes 2 No Directo Maryland Harford Aberdeen 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò the Medical Examiner rount be items 23e 602 Shirley Drive 21001 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0020 "naturel", or 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary U.S. Government other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 end 2 should be fii I Health end Mentel H tem 27 Is marked oth Be Joseph Duda Jadwiga Michon Depertment of Health and Men Important: If Item 27 Is marke any Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward W. Barsam 602 Shirley Drive, Aberdeen, Maryland 21001 Baltimore, 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Peges 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 1/15/98 Aberdeen, Maryland 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 ang 21 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** 18 Y+RS. /Medical Immediate Cause (Final disease or condition resulting In death) SUBARACHNOID HEMBERA GE Examiner Due to (or as a consequence of): RUPTURED CERETSRAL ANEWRYSM Examiner Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last end physician ar Box 68760 Physiclan/Medicai Due to (or as a consequenca of): P.O. Part II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, á 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital al or Attending Physicien: T s effer death. I Director: After this certificat ed in by the funeral director, p. certifical 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours ef the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signature of 196 of continue 29c. License number D 1599 4 29d. Date signed (Month, Day, Year) 1-12-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LETTCUM S. GALVEZ MD. 625 S. UNION AVE. HAVRE DEGKACE,

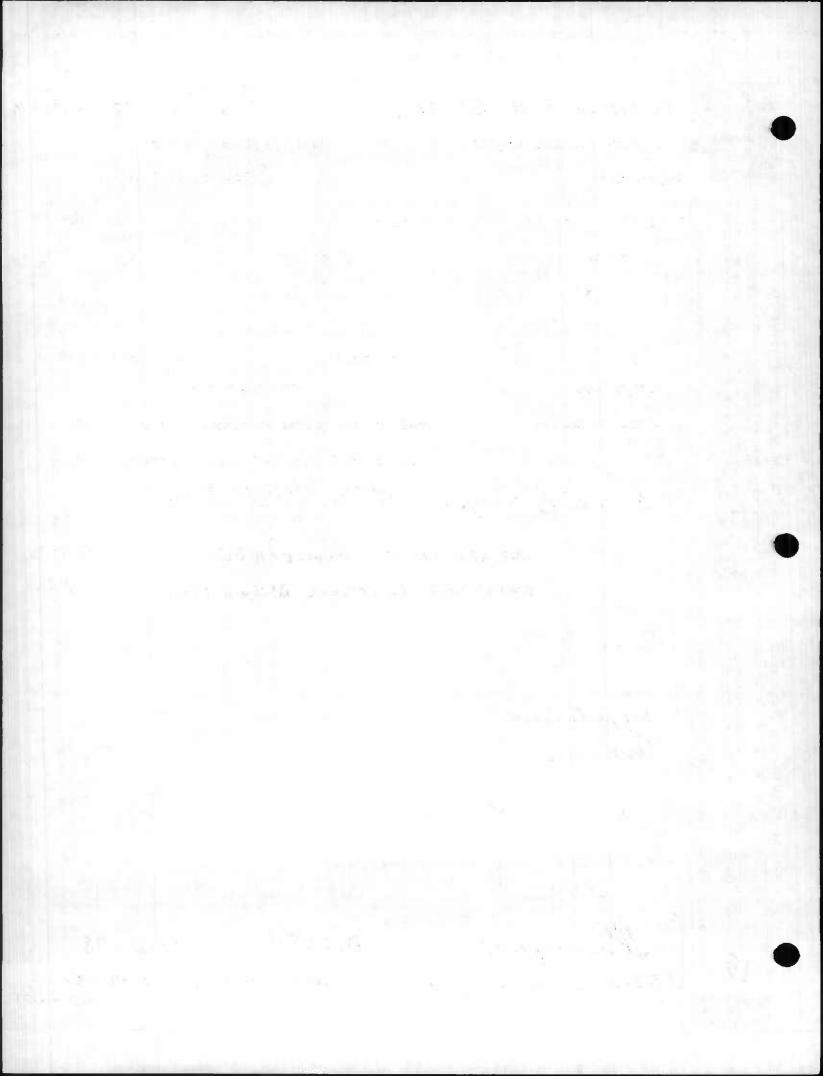
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GALVEI MD. 32. Registrer's Signature

Istrer's Signature Rardall

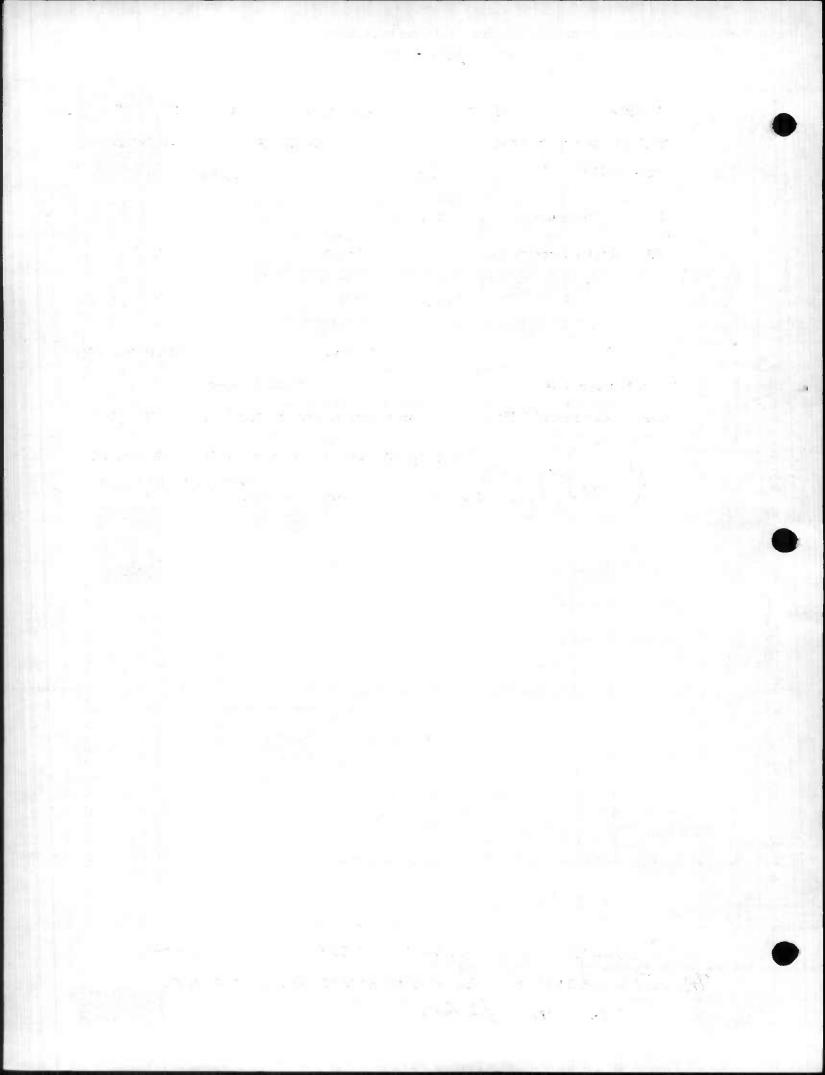
State Registrar 31. Date filed (Month, Day, Year)

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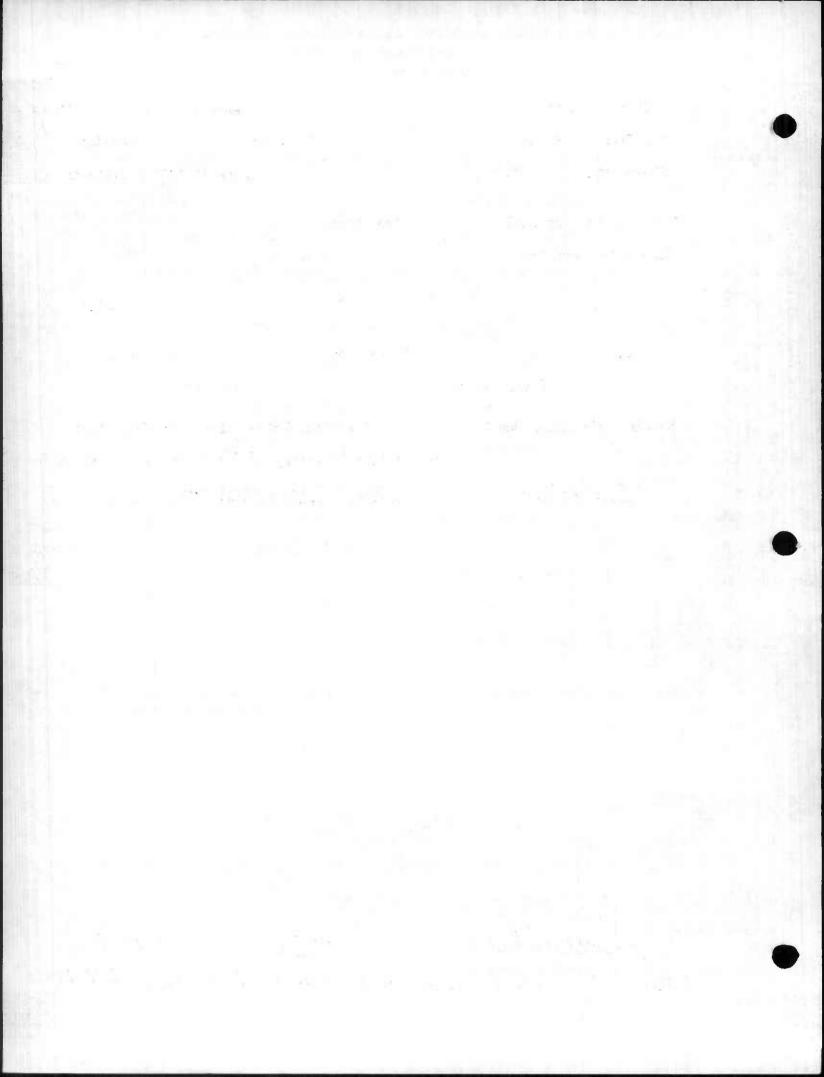
State of Maryland /-Department of Health and Mental Hygiene

d Mental hygiene. marked other than "natural", or items 23s or 28s-f show marked other than "natural", or items 23s or 28s-f show marke event, the Madrian Exemples must be notified at contract or the Madrian Exemples of the Complex of the Comple		1. Decedent's Nama (First, Middla, La PRESTON 4a. Facility Nama (If not institution, giv 8919 GREEN BRAN 5. Social Sacurity Number 221-18-2532 Usual Rasidance of Dacedant 10a. Stata 10b. County MD Wicomic 10e. Street and Number 8919 Green Br 11. Marital Status 1 Nevar Married 3 Widowad 4 Divorced 15. Decedant's Et (Specify only highast gray	JAMES a street and number) CCH ROAD Sax M 2 F	(In yrs. las 6 10c. City, 7 Wil	8 Yrs.	If Und Month	ar 1 Yaar	4b. City, Town, WILLARI If Undar 24	or Locat	Data of Death Month O1 ion of Death Data of Birth (Month, Day,)1-10-2	Day O6 4c. County WICOM	ICO	O3.	
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Hygiene. ther haturent, me Medical	- Aller	15. Decedant's Ed (Specify only highast gra			ľ	if Yas, sp	edent of I ecify Cub	lispanic Origin an, Maxican, P Specify:	? (Specification Rice	y Yas or No- an, atc.)		e - Amarica ck, Whita, at wh	c.	
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		17. Fathar's Nama (First, Middla, Last)						18. Mothar's	Nama (F	īrst, Middla, M				
		Herman Campbel						Edna	Tra	ader				
9 8		19a. Informant's Name/Ralationship (Gladys Campbel	Type, Print)			_		and Number of Branch						
Department of Haalth important: If Itam 27 I any Injury or other troonce.	1	20a. Mathod of Disposition Disposition Clarification 3	Ramoval from Stata	селт	e of Dispo	natory of	r othar pla	,			20c. Location	City or Tow		
Department of the Important: If its any injury or of once.	-	4 Donation 5 Other (Specif		Shii				Garde		rbage	-			
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ysician Medical aminer	1	234 Parl 1. Enter the file-stage or com- phick, or heart failure. Let only Immediata Causa (Final disease or condition rasulting In death)	a. CHRONIC		RUCTI	VE I	PULMO				st,		Approximat ntarval Bat Onsat and I	tween
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sate has been signed by page 2 should be det										24a. Was ar perform	autopsy ned?	avai	a autopsy f labla prior t pletion of c eath?	to
page 2										1□ Ya	s 2 No	10	Yas 2□	No
E 0 0		25. Was casa rafarred to medicel						26. Placa of	Daath (C	check only ons	a)			
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al Director: After ted in by the funeral Certification:		2 Accidant Invastigation 3 Sulcida 6 Could not be datarmined		ry - At home (Specify)	a, farm, stre				28f.	Location (Str City or Town		per or Rural	Routa Num	iber,
Funer (sely fill		29a. Cartifiar 1☐ Cartifying Ph (Check only one) 2☒ Madical Exam	ysicfan: To the bast of ainar: On the basis of and manner state	axamination	dga, daath and/or inv	occurre vastigatio	d at tha th	ma, data and p opinion, daath o	lace, and	dua to tha ce at tha tima, da	usa(s) and ma ita and place,	annar as sta and dua to t	ted. ha causa(s	s)
To the comple		29b. Signatura and titla of certifiar		2144	0.00	2	9c. Licens	a number		29	d. Data signa	d (Month, D	ay, Year)	
	3	30. Name and andress of person who	completed cause of de		M.E.		00359	9		01	06-98			



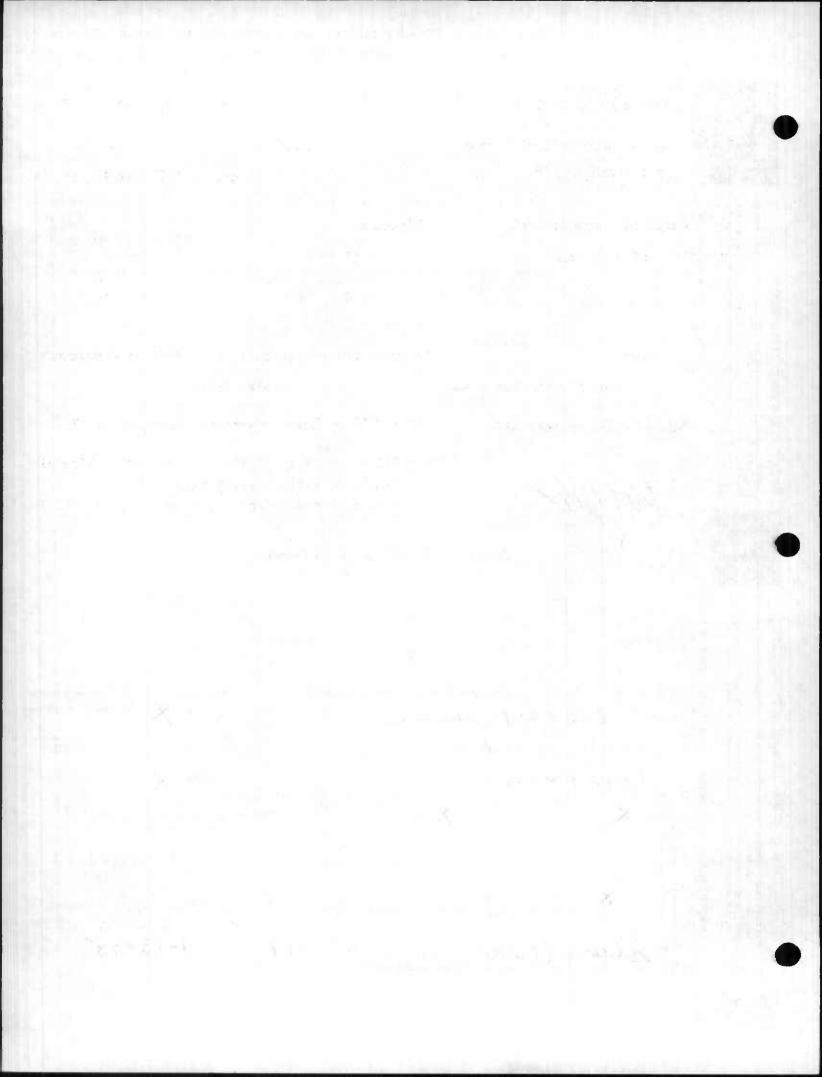
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	1 Deceded Name (First Middle	(and		Certific	cate of I	Death		Reg. No.		76
nysician	1. Decedent's Nema (First, Middla,	•					2. Data of Dee Month	Dey	Year	ma of Deeth
Medical	Dorothy V. Cata						January			20 AM
xaminer	4a. Facility Name (If not Institution,)		4		r Location of Deeth	4c. County	of Deeth	
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neral ector	319-26-1982	5. Sex 7. A 1 M 2 F	ga (In yrs. last bir 65		Inder 1 Year oths Days	If Undar 24 H Hours Mi		, Year) , 1932	9. Birthplace (S Country) Illinoi	tata or Foreign
	Usual Residence of Decedent 10a. Stete 10b. County		10c. City, Town	or Location	1				10d Insi	de City Limits
lor lor	Maryland Anne	Arundel		Clan	Burnie				-7.9	Yes 2□No
Tec	10e. Street and Number	ni dilder			f. Zip Code		T .	10g. Citizen of \	Whet Country?	
3 0	8189 Great Bene	d Road			21	061			USA	
To Be Completed by Funeral Director	11. Maritel Status 1 Never Married 2 Marrie 3 Widowed 4 000 vorced	12. Was Decedant Armed Forcas; d 1 Yes 2 If Yas, Giva Yaar or Dates:	?		ecedant of H specify Cube s 2 No		(Specify Yes or No- erto Rican, atc.)	14. Rac Blac Specify	e - Amarican India ck, White, etc.	an,
Completed by	15 Decedent's	Education	16e.	Decedent's	Usual Occup	ation		16b, Kind of B	White usiness/Industry	
ple	(Specify only highest	grade completed) College (1-4or	54)	(Giva kind o life. DO NO	of work done of OT use retired	during most of w	rorking		,	
Š	Elementary/Secondary (0-12)	Conlege (1 40)	54)	Bookk	eeper			Arunde	1 Lodge	
Be	17. Father's Name (First, Middle, La					18. Mother's N	ame (First, Middle,	Meidan Sumen	ne)	
10		Oscar Lar	son				Ann Min	уо		
	19e. Informant's Neme/Relationshi	p (Type, Print)	19b	Mailing Add	dress (Street	end Number or i	Ru <i>ral Rou</i> ta Numbe	r, City or Town,	Stete, Zip Code)	
puce	Dottie Plakota	ris/ Daught	er 1	36 Is	land V	iew Dri	ve Annap	olis, M	ld. 21401	
	20a. Method of Disposition 1 Durial 2 Decremation 3	□Removel from Stets	20b. Piece of cemeter	Disposition y, cremetory	(Neme of or other piec	e)	ve Annap Date	20c. Location -	City or Town, Sta	ta
	4 □ Donation 5 □ Other (Spe		Metro	polita	an Cre	matory	1-13-98	Alexand	ria, Vir	ginia
d d	21. Signature of Funeral Service Un	bunsee		22. Nam	e and Addras	ss of Facility				
8	Valatil Illi	1		Geor	ge P. I	Kalas F	uneral Ho and Rd. E	me	W1 0	1007
	23a. Part1. Enter the disease, or or	omplications that cause	d tha death. Do r	not enter the	mode of dyln	g, such as cardi	and Rd. E	agewate rest,	Appro	dmete
n	shock, or heart tailure. List or	nly one cause on each I		1	7.1				Onaet Onaet	I Between end Death
al .	Immediate Cause (Final		Re	nal	cell	cauc	ev		121	2 Yrs.
er	disease or condition resulting in death)	θ	Due to (or es e							
Je L			Due to (01 es e t	on sequence	x 01).				1	
Examiner	Sequentielly list conditions.	b	Due to (or es a o	onsequance	of);					
Ä	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated exists.)									
ca	thet initiated events resulting in deeth) Last	C	Due to (or as a c	onsequance	of):				i	
Physician/Medical	resulting in Geenly Last								İ	
and a		d							1	
SICI	Part II. Other significant conditions	contributing to death b	out not rasulting in	tha undarly	Ing cause give	en in Pert I.	23b. Did to	obacco use co	ntribute to the ca	use of death?
Phy							101	08 2 No	3 Probably	4 🗌 Unknow
b							-			
							24a. Was e	en eutopsy	24b. Were auto available p	
Completed							-		completion of death?	n of cause
E							1 D Y	as 2000	1 ☐ Yes	2□ No
0	25. Was case refarred to medical					26. Plece of D	eath (Check only or	~	1	
O	examiner?	Hospital: 1 ☐ Inpati	ent 2 ER/Ou	toatient 3	DOA Oth			ence 6 □Oth	er (Specify)	
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윺	1 Naturel 5 Pending 2 Accident investigation	(Month, De	y rear) II	njury M	Worl	K? Yes 2 □ No				
Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homldde determin	ad 286. Piece of in	ury - At home, ta c. (Specify)	rm, street, fe	octory, office		28f. Location (S City or Tow	treet and Numb n, Stete)	per or Rurai Route	Number,
	29a. Certifier 1 Certifying	Physician: To the best caminer: On the basis of	of my knowledge	death occu	rred at the time	ne, dete and pia	ca, and dua to the c	ause(s) and ma	anner es stated.	uso(s)
Cal		and mannar st	ated.	201 III Costige	attori, writing of	onion, daam oo	curred at the time, c	oto ond place,	and due to the ca	use(s)
edical	one)	_			29c. Licensa	number		29d. Date signe	d (Month, Day, Ye	ar)
Medical	29b. Signature and the of cartifier	21.5010-			010	COO			1001	
Medical	one)	millu			010	COO			1001	
Medical	one)	well was	leath (Itam 23a) (Type_Print)	010	COO			1001	
edical	29b. Signature and the of cartifier	well wo	death (Itam 23a) ($\mathcal{U}_4 \mathcal{O}_4$	Type, Print)	010	COO	Rd. Ac		1001	



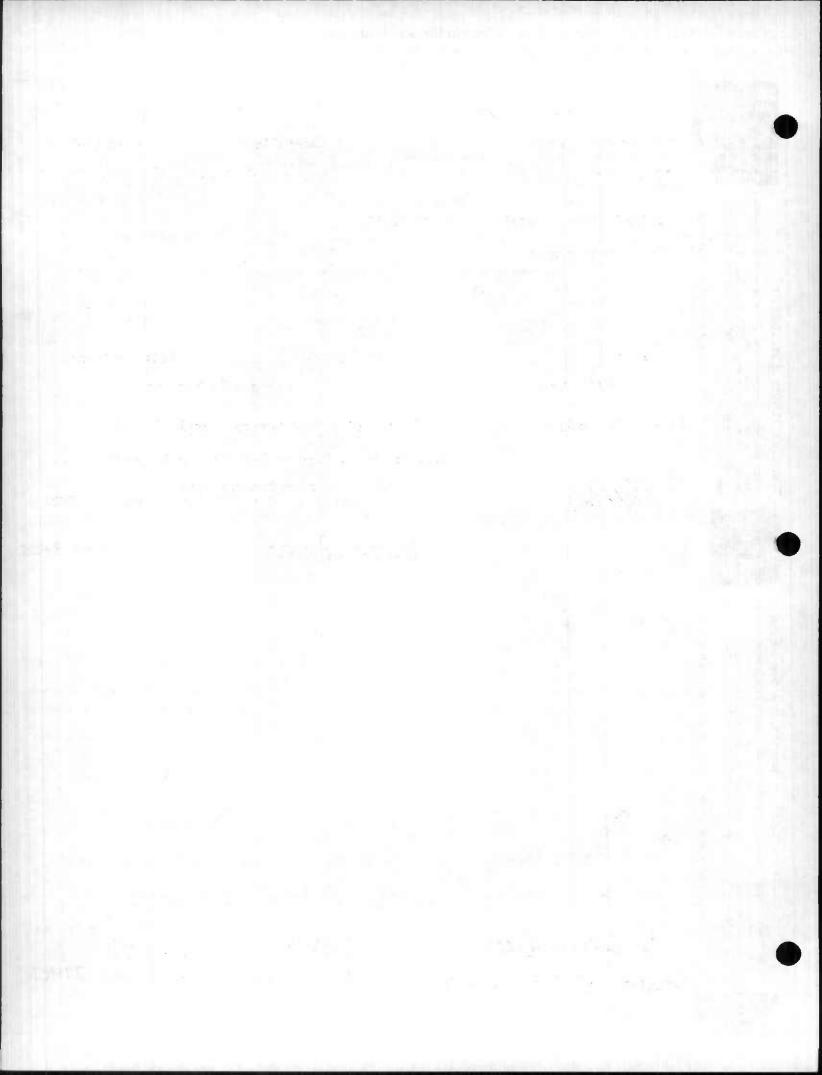
State of Maryland / Department of Health and Mental Hygiene

						Certificate	e of De	eath	,	Reg. No.	0 2	- 0 2	
п	Physici		1. Decedent's Name (First, Middla, La George M. Cleme						Januar		9 98 r	3. Time of 12:3	of Deeth 9 AM
	/Medic Examir		4e. Fecility Name (If not institution, gire	ra street and number)			4b. 0	City, Town, or L	ocation of Death			12.0	7 1111
			Anne Arundel Med	ical Cente	er			Annapol	is	Anne	Arun	del	
	Funeral Director		5. Social Sacurity Number 6. S 577–18–8639 Usuel Residence of Decedent	Sax 7. Ag 1XXM 2□ F 80	ga (In yrs. last birt	thday) If Under Months Months		Annapol Under 24 Hrs. Hours Min.	(Month, De		9. Birthpl Count	ace (Stete	or Foreign
	how		10a. State 10b. County		10c. City, Town	or Location					10	d. Inside (Dity Limits
	Sa-f s	Director	Maryland Anne Ar	undel	E	dgewater							s 2 No
	with the or 2	D	10e. Street end Number			10f. Zip				10g. Citizen of		ry?	
	me 23	Funeral	1637 Hilltop Road	12. Wes Decedent	Ever in U,S.		1037 ent of Hispe	nic Origin? (Sp	pecify Yas or No-		USA >a - Amarica	in Indien,	
020	iled within 72 hours after death with the Maryland Hygiene. Ifter than "natural", or items 23s or 28s-f show ent, the Madical Examiner must be northed a	by	1 Never Merried Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		ff Yes, speci		Mexican, Puerto Pec <i>ify:</i>	Rican, etc.)		ck, White, e		
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ore.			20a. Method of Disposition 1 Burial 2 Cremetion 3 D		20b. Plece of	Disposition (Nam y, cremetory or oti			Dete	20c. Location -			
Ĕ	. Peges tment of t tant: If its jury or of		4 □ Donation 5 □ Other (Spacin	ý)		politan (Alexand	dria,	Virg	inia
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	/Medical Examiner	er	Immediate Ceuse (Final disease or condition resulting in death)	e. my	O Cardo	onsequenca of):	farc	tron			1 1	minut	es
oʻ	fricete be executed g physician and as the burial-fransit	Examiner	Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Diseasa or Injury that initiated events	b. ————	Due to (or es e c	onsequenca of):							
x 58/50,	2 0 0	/Medicai	Cause (Disease of Injury that initieted events resulting in deeth) Last	d	Dua to (or as a co	onsequence of):							
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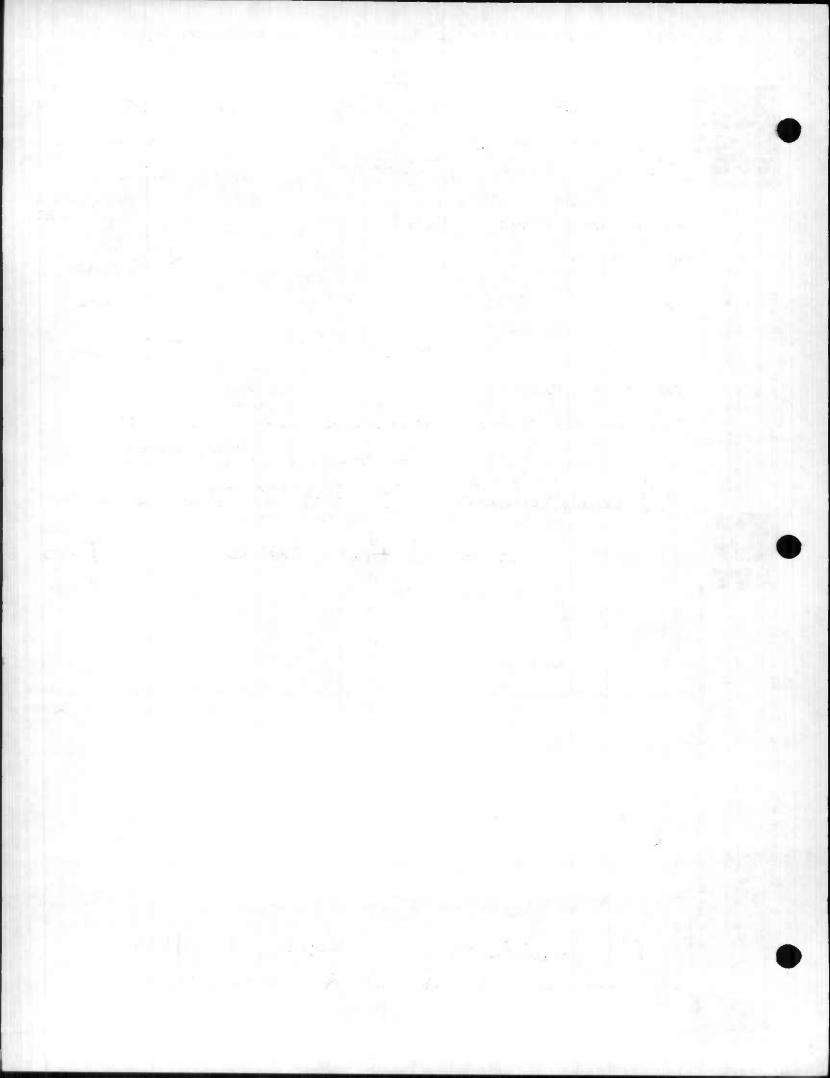
State of Maryland / Department of Health and Mental Hygiene 8

						Ce	rtificate o	f Death		Reg. No.	0	C O J -1
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1	Exami		4e. Facility Name (If not institution, g		-			4b. City, Tow	n, or Location of De		County of Death	
1			1040 Boucher Ave	niie				Annono	1:0	A	A	
	Funeral			Sex	7. Age (In vr	s. lest birthday)	If Under 1 Ye	Annapo er If Under 2	4 Hrs. 8. Date of E	Birth	nne Ar	
п	Director			1□M 2XF	50	Yrs.	Months Day	/s Hours	4 Hrs. 8. Date of E Min. July 1	Dey, Yeer) 5, 194	7 Wos	nplaca (Stete or Foreign untry) t Virginia
			Usual Residence of Dacedent				1		quiy i	J, 1)4	/ WES	c viiginia
	/land		10a. State 10b. County		10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	Me 4 s	ō	Maryland Anne A	rundel		Annap	olic					1XXes 2□ No
	the 28s	Director	10e. Street end Number			minap	10f. Zip Code			10a Citiza	en of What Cor	untn/2
	with and	Ö	1040 Boucher Ave	niie				1403		rog. Onize	US.	
	72 hours efter deeth with the Meryland natural, or Hems 23a or 28a-f show pical Examiner must be notified at	Funerai	11. Marital Status		edent Ever in	118 12			in? (Specify Yes or I	10 14	I. Rece - Amer	
_	Hen Hen	5	1 Never Merried 2 Married	Armed Fo	orces?	0,0.	If Yes, specify C	uban, Mexican,	Puerto Rican, etc.)	19	Black, White	
Baltimore, Maryland 21215-0020	rs ef	by F	3 Widowed 4 Divorced	1 ☐ Yes If Yes, Gir Year or D	AG		1□ Yes 2√2	lo Specify:		s	Specify: LT	hite
Ş	hou	ğ			A165.					400 100		
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12	within ene. than	E	Elamantary/Secondary (0-12)	Collaga (1-4or 5+)			,				
D	Hygi ther int,	Ö	12th 17. Fether's Name (First, Middle, Las	t)) 3	elf Emp		's Name (First, Midd	Ha Maiden S	ir Des	igner
an	d d d d d d d d d d d d d d d d d d d	Be	Bill Bo	•					Anna Dell			
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á	1 end Heelth em 27		Matthew B. Cubba	ge/ Son		107	Loving	Road S	Severn, Ma	ryland	1 21144	
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트	Pa ant: ury		4 ☐ Donation 5 ☐ Other (Spec	fy)	La	kemont	Mem'1.	Gardens	s 1–16–98	David	lsonvil	le, Md.
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o.	the de	Physician	Pert II. Other significant conditions	contributing to de	eath but not re	sulting In the u	nderlying cause	given In Part I.	23b. Di	d tobacco u	ae contribute	to the cause of death?
0	law requires thet the death c es been signed by the ettend s 2 should be deteched for us								10	Yes 2	No 3□ Pr	obably 4 Unknown
ŝ	signed to det	b										
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Division of Vital Records,	ysiclan: The I is certificate he director, page	Bec	25. Was casa referred to medical					26. Placa o	of Daath (Check only	ona)	24	
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0	oth. : After e funer	tio	1 Natural 5 ☐ Panding 2 ☐ Accidant investigation		th, Dey Year)	Injury		/ork? ☐ Yes 2 ☐ No	0			
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á	Oir Dir	Certification:	4 Homicida	buildi	ng, etc. (Spec	ify)			City or T	own, State)		
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	To the Hospital or Attending Ph within 24 hours efter deeth. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and filtre of certifier	and main	Gracou.		29c 1 ice	nse number		29d Date	signed (Month	Day, Year)
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State of Maryland / Department of Health and Mental Hygiene 8 02095

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Physician /Medical		Joh	n	Willi	S		Cla:	rk	Ja	anuary	8 19	998	1:40	0 AM
Examiner	-	4a. Facility Nama (If not institution, g	give street end number)				4b. City, Town	n, or Location	on of Death	4c. County	of Death		
		Frederick Me	norial Hos	pital				Freder			Freder	rick (Count	ty
Funeral		5. Social Sacurity Number 6		ge (In yrs. la:	st birthday)	If Unde Months	1 Year Days	If Under 24	Hrs. 8.	Data of Birth	Yead 919	9. Birthpla Countr		
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or 20	5	10e. Street and Number				10f. Zi	Coda				og. Citizan of V United			
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to f Health and Mentel Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumetic event, the Medical Examiner must be notified at or other traumetic event, the Medical Examiner must be notified at or other traumetic events.	5	11. Maritei Stetus	12. Was Dacedani Armed Forcas	Ever in U,S.	. 13. V	Vas Dace	dent of h	lispenic Originan, Maxican, I	n? (Specify	Yas or No-		e - Amarica ck, Whita, e		,
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Man T	d	Elementary/Secondery (0-12)	College (1-4or	5+)				during most o	, working		United			
th th	5	12			Posta	1 Car	rrie	r			Posta:	l Serv	rice	
d oth		17. Fathar's Name (First, Middle, La	st)					18. Mother's	s Nama (Fi	rst, Middla, N	Aaiden Sumen	10)		
Mentel is arked of atic eve	0	Charles Harper	Clark					Anna	a Evai	ns	_			
DUE DUE		19e. Informant's Name/Relationship	(Typa, Print)		19b. Mailin	g Addras	s (Street	end Number	or Rural Ro	outa Number,	City or Town,	Stete, Zip (Code)	
Health a tem 27 le other tra		Cheryl Williams	/ Daughte:	r	23 Wo	odsi	le C:	ircle,	Evan	s, Geo	rgia 30	0809		
Department of Health and Mentel Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mance. To Be Comp		20a. Method of Disposition		20b. Ple	ne of Dispo	sition (Na	ma of	ca)	Tane	ata a	20c. Location -		n, Stata	
y or H	1	1 X Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spe						al Parl	k In	1998	August			
in the state of th	-	21. Signature of Funeral Service Lie						ass of Facility	109	1779	Georg.	La		-
Department of I Important: If ite any injury or of once.			1/4 "11000.		E:	liot	Son	ns Fune						
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month :05 4e. Fecility Neme (If not institution, give street and number) Chambers 3 1598 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) _eFuneral 1X M 2□ F Deys Yrs Director 217-60-0055 46 Dec. 16, 1951 Maryland Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show 1 ☐ Yes 2X No Director Maryland Fallston Harford 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? death with 2608 Harford Road 21047 USA Funeral нетв ; 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. "natural", or items Peges 1 end 2 should be filed within 72 hours efter or ment of Health and Mental Hygiene.
ant: If Item 27 Is merked other than "natural", or itee ury or other traumatic avent, the Medical Examina 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 21215-0020 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 4 Meteorology Technician U.S. Government Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Thomas Rollins Chambers Margaret Lee Smith 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Margaret Chambers - Mother 2608 Harford Road, Fallston, Maryland 21047 Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete Buriel 2 Cremetion 3 Removel from State Depertment of Important: If eny injury or pace. 4 ☐ Donetion 5 ☐ Other (Specify) Bel Air Memorial Grdns. 1-13-98 Bel Air, Maryland Of Funeral Service Line 22. Name and Address of Facility
Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD dinter the disease or complication, that k, or heart teilure. List only one cause or Do not enter the mode of dylng, such es cerdiac or respiratory errest, Approximete Physician /Medical Immediate Cause (Final diseese or condition resulting in deeth) 00 Examiner Due to (or es e consequence of) Physician/Medical Examiner The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest end Due to (or es e consequence of): physician Box 68760 Due to (or es e consequence of): been signed by the ettending I should be detached for use as Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, à 24b. Were eutopsy findings eveileble prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No this certificate Division of Vital or Attanding Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpetient 2 ☐ P/Outpetient 3 ☐ DOA funeral 28e. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident efter death Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner steted. 29a. Certifier Medical (Check only one)

29c. License number

D08546

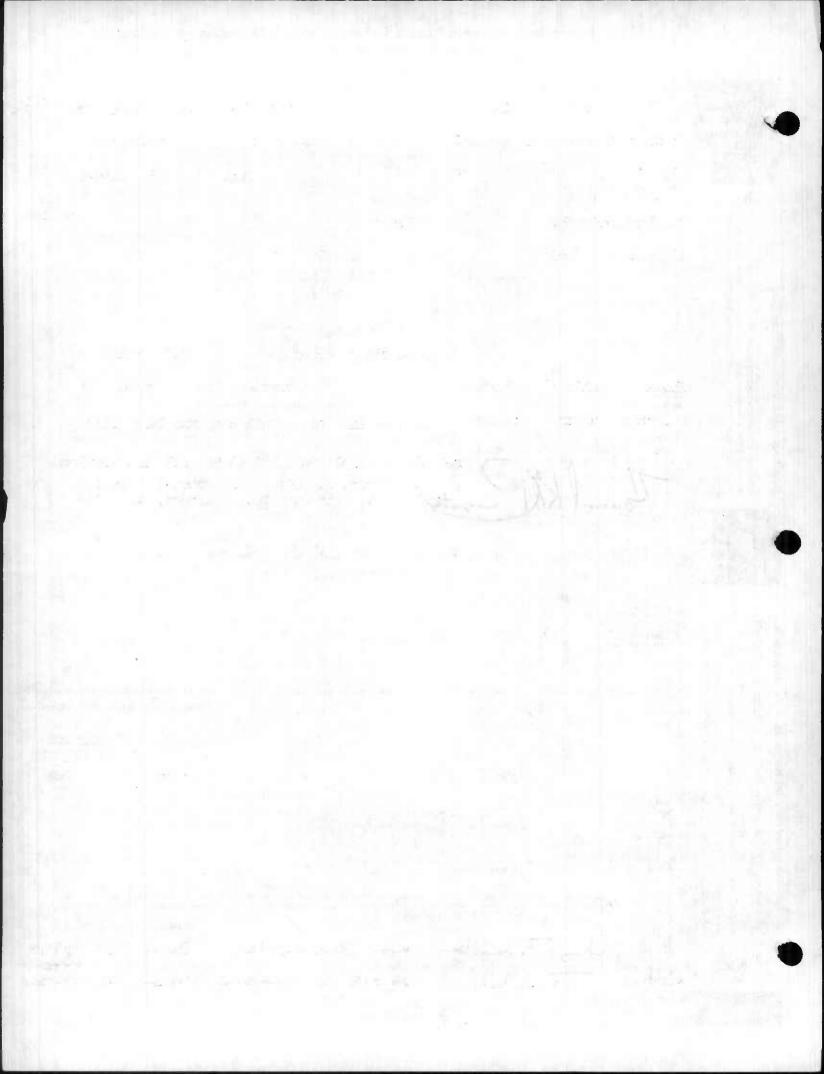
29d. Date signed (Month, Dey, Yeer)

State Registrar 29b. Signeture end title of certifier

Sonw

8218 WIS COUSIN 32 Aggistras's Signature

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

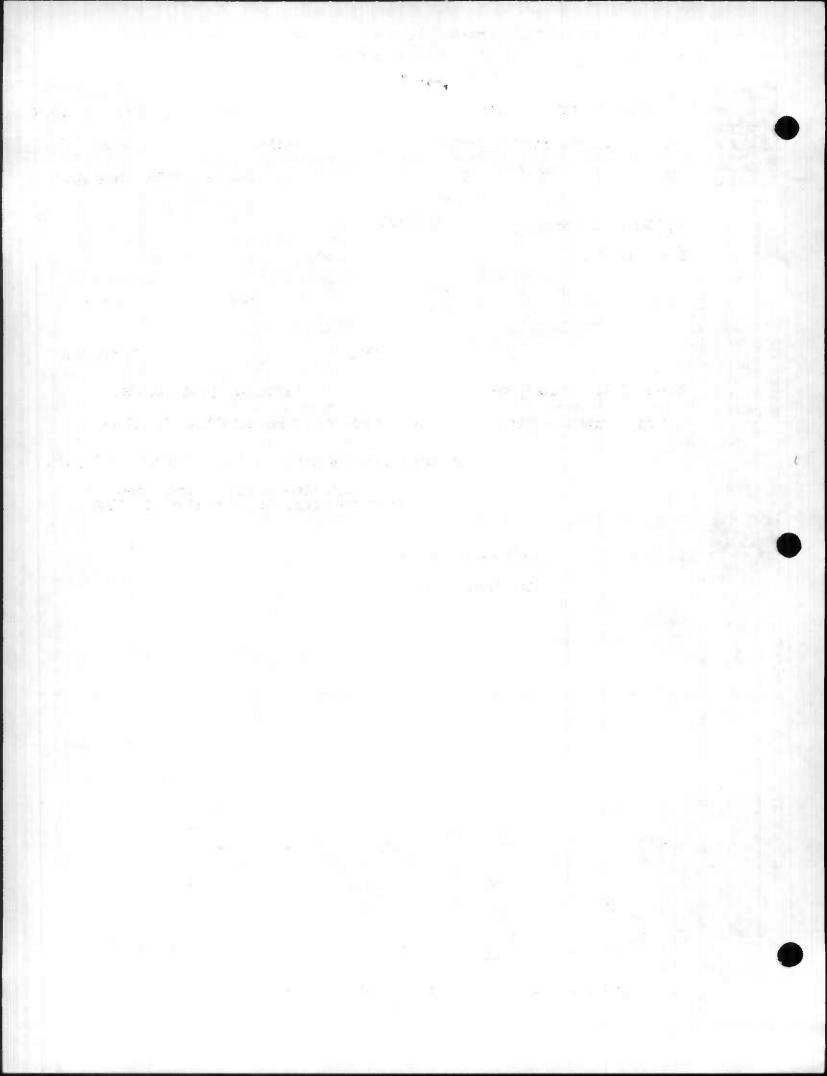


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No: 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Yee **Physician** ALVAREZ JOSEPH COSTE 9, 1998 8:50 AM Jan. /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** ER Fallston General Hospital Fallston Harford if Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** 1**∑** M 2□ F Days Hours Yrs. Director 437-58-4850 61 Dec. 15, 1936 Louisiana Usuel Residence of Decedent the Marylend 10e. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than 'neturel', or items 23e or 28e-1 show treumstic event, the Madical Example fress be notified at 1 ☐ Yes 2 No Director Jarrettsville Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 3816 Rush Rd. 21084 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. Peges 1 end 2 should be filed within 72 hours efter of the fold Health end Mentel Hygiene. Int: If Item 27 is merked other than "natural", or ite 1XI Yes 2 No 1960− If Yes, Give Yeer or Dates: 1980 1 ☐ Never Married 2 X Married Yes 2□ No Mexican Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Соmpleted 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Military US Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 0 Uless (u/k)Coste', Sr. Victoria (u/k) 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Maxine B. Coste' - Wife 3816 Rush Rd., Jarrettsville, Md. other Baltimore, 20b. Plece of Disposition (Neme of cometery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State injury or Depertment Important: If Jarrettsville Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 1-13-98 Jarrettsville, Md. 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician /Medical Immediate Ceuse (Final Metastatic Cancer disease or condition resulting in deeth) Examine Due to (or es e consequence of): Examiner Carcinoma Lung physicien end the buriel-transit thet the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): 80 ettending I signed by the et d be detached for Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? O 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Wes en eutopsy performed? Completed peed hes 1 ☐ Yes 21X No certificate 1 ☐ Yes 2 X No Division of Vital director, Be 25. Wes cese referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P this funeral 27. Menner of Deeth Certification: 28b. Time of 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? After 5 Pending Investigation 1 Naturel i or Attending s efter death. 1 ☐ Yes 2 No NA NA M 2 Accident NA in by the 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours of To the Funeral Di NA 1 Certifying Phyelcian: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. edicai 29a, Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME Jan. 9, 1998 DME 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) G. S. Prabhu MD, 218 Fulford Ave., Bel Air, MD 21014 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State alia Savilen Radall Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 3. Time of Death 198 2130

	Decedent's Name (First, Mid	Idle (est)		Certii	ficate of	Dealli	2. Date of Deat	ng. No.		3. Time of Death
Physician		ETTY CROU	CF.				Month	Dey	Year	
/Medical	4e Facility Neme (If not instituti					4b. City, Town, or I	January	4c. County	of Death	2130
Examiner	Laurelwood Nu					Elkton	LOCATION OF BOATS		Cecil	
	5. Social Security Number	6. Sex	7. Age (In yrs. lest I	birthdev) II	f Under 1 Year		8. Date of Birth			ace (Stete or Foreign
Funeral Director	220-22-7915 Usual Residence of Decedent	1□ M 2፟፟ቚ F	80	Yrs.	lonths Days	Hours Min.	8. Date of Birth (Month, Dey, Jan. 23	, 1917	Nort	ece (Stete or Foreign ny) th Carolina
naturel; or items 23a or 28a-f ehow dical Examinat must be notified at sted by Funeral Director	10a. State 10b. Coun	ty	10c. City, To	wn or Locati	ion				10	d. Inside City Limits
28a-f ehow	Maryland H	arford	F	orest	Hill					1 ☐ Yes 2 🕱 No
or 28s	10e. Street and Number				10f. Zip Code		1	0g. Citizen of V	Vhat Count	ry?
r items 23a or 28a-fel niner must be notified Funeral Director	315 Montgomer	y Dr.			21050			USA		
items 2	11. Marital Status	12. Was Dec	edent Ever in U,S.	13. Was	s Decedent of	Hispanic Orlgin? (S pan, Mexicen, Puert	pecify Yes or No-		e - Americe k, White, e	
or the	1 Never Married 2 Ma		2 XNo		Yes 2 No		o moan, otc.,			
Eres	3 ☐ Widowed 4 ☑Divorce	ed Year or D	ates:					Specify	Whi	ite
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Health and Mental Hyg tem 27 is marked othe other traumatic event, To Be C	19a. Informant's Name/Relation Virginia M. B		daughter	315 M	10ntgom	ery Dr.,				
of He or oth	20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation	3 Removal from	State 20b. Place ceme	of Disposition tery, cremeter	on (Neme of ory or other pla	ace)	Date	20c. Location -	Cify or Tov	wn, State
ment ant: i	4 Donation 5 Other		Bel			Gardens		Bel Ai		
Department of Health a Important: if item 27 is eny injury or other trau	21. Signature of Fundad Service Description:	Ciconsul VIII	mas	22. N HOW 50	ame and Addr vard K. W. Bro	ess of Fecility McComas adway, Be	III Fune	ral Hom D 2101	ne, P.	.A.
hysician	23a. Parf1. Enter the deeds a, shock, or heart the unit Li	or complications that of st only one cause on e	caused the death. Deach line.	o not enter t	he mode of dy	lng, such as cerdiad	or respiratory err	est,		Approximate Interval Batween Onset and Death
/Medical	Immediate Cause (Final disease or condition		Myss		TI	far the			1	tours
xaminer	resulting in death)	a	Due to (or as	a consequer	nce of):	farction Disense				
			COSTON	ant i	Arter	A French	,		1	leare
nd trans	Sequentially list conditions,	6.	Due to (or es	a consequer	nce of):					
g physician and es the bunel-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Atrial	F	brilla	tion			1	E and S
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sic	Part II. Other significant condi	tions contributing to d	eath but not resulting	In the unde	rrying ceuse g	iven in Pert I.	23b. Did to	bacco use cor	ntribute to	the cause of death?
ate has been signed by the ettendin page 2 should be deteched for use Completed by Physician/M	17	pertrialye	eridens.	4			1□ Y	es 2 No	3 Prob	abty 4 Onknown
ate has been signed by the ettendingage 2 should be deteched for use		01					24a. Was e		eve	re eutopsy findings ilable prior to
has be									of c	npletion of ceuse leeth?
page Com										

115540

12,1998

25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

Mauldin

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one)

29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie

MD 30. Name and addre who completed cause of death (Item 23a) (Type, Print)

G

North End Md 21901

Avenue Registar's Signature
Fully Davidson-Rardall

Division of Vital Re Hospital or Attending Physician:
 24 hours effor death.
 Funeral Director: After this certificalety filled in by the tuneral director, I To the To The To the F

: After this certificate has funeral director, page 2

Be

Certification: To

Medical

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? #22 AMEND#1,10c,19a,19b 1/22/98 cms AACO HEALTH Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** HOTOID Dunire Eugene 745 P.M. 1998 /Medical monuary 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVTLLE
If Under 1 Year | If Under 24 Hrs. | 8 Dete MONTGOMERY

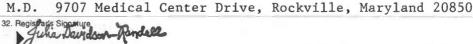
9. Birthplece (State or Foreign Country) 5. Sociel Security Number 8. Dete of Birth (Month, Dey, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Deys Hours Min. Yes 236-54-0457 56 Director January 30,1941 West Virginia Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner mant be notified at West 1 Yes 2 No Director Pocahontas Marlinton Marlington Virginia 10e. Street end Number 10g. Citizen of Whet Country? United States 10f. Zip Code death with Route 1, Box 162B 24954 of America Funeral 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S Armed Forces? 14. Rece - American Indien, Black, White, etc. filed within 72 hours efter 1 ☐ Yes 2 📉 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural". Completed the Medical 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then Elementery/Secondary (0-12) Hygiene. College (1-4or 5+) Construction/ Heavy Equipment Operator Coal Mine-Production Is marked other traumatic event, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) es 1 end 2 should be fill of Health end Mental H Item 27 is marked oth Be Carl Ward Dumire Anna Ruth Moss 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Route 1, Box 162B, Markinton West Virginia 24954 Creola Jane Dumire /Wife 20e. Method of Disposition Dean-Dumire/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) other Baltimore, 20c. Location - City or Town, State Date Peges 6 W Burial 2 ☐ Cremation 3 ☐ Removel from State Slaty Fork January = 0 Depertment Important: If any Injury or Gibson Cemetery 16, 1998 West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signe of Funeral Service Licensee #M00690 22. Name end Address of Fecility VanReenan Funeral Home (au son Marlington, West Virginia Marlinton, West Virginia Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Telanoma Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of) Examiner The law requires that the deeth certificate be executed buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. physician Physician/Medical the Due to (or es e consequence of): 80 USB Por P.O. Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 8 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? should Completed 24a. Wes en eutopsy need performed' Pes page 2 certificate 1 Yes 2 N No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director. 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No Certification: To this 28e. Date of Injury (Month, Dey Yeer) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending death. 1 Yes 2 No investigetion 2 Accident 24 hours efter deal 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 29a. Certifier Medical completely 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) within 2

State Registrar 31. Date filed (Month, Day, Year) JAN 16 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature end title of certifier

Joseph M. Haggerty,



29c. License number

D32407

29d. Date signed (Month, Dey, Year)

January 12, 1998

Khunandhanan Harrie James Hallmann o.

August Despekty post

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene 3 1 2 1 0 0

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Examin	er	UNIV. of MAR				-10-		BAUN!	or Location of De		unty of Death	- 0-1
		5. Social Security Number	6. Sex			lest birthday)	If Undar 1 Yes				9 Births	
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or items	by Funeral Director	11. Marital Status 1 Navar Married 2 M	arried	12. Was Decedant Armad Forcas 1 Yes 2 If Yas, Giva	?		Was Decedent of f Yas, specify Cu I □ Yas 2√2 No		(Specify Yes or I uarto Rican, etc.)		Raca - Americ Black, White, ecify:	etc.
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27 ls		NANCY J. BEAR	D, D	AUGHTER		5129	BAND HA	LL HILL	RD, WES	MINSTE	R, MD	21158-1405
- 2		20a. Mathod of Disposition 1 → Burial 2 → Crametion 4 → Donation 5 → Other		amoval from State		cematary, cran	sition (Nama of natory or other pi	ace) ORIAL PI	Data 7 1 /1 7		on - City or To	
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State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Name (First, Middle, Last). 2. Dete of Deeth 3. Time of Death Month 250 **Physician** DERRENBERGER SANUARY 10, /Medical Am 4b. City, Town, or Location of Death / 4a. Fecility Name (If not institution, give street end number) 4c. County of Death **Examiner** KONTHUEST HOSPITAL CENTER PANDALLS TENN BACTIMONE 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Jan. 25, 1927 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Director 217-22-7939 Maryland Usual Residence of Decedent the Meryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at MD Carroll Eldersburg 1 Yes X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6304 White Cedar Court 21784 U.S.A. deeth 12. Was Decedent Ever in U,S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: 1944–46 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2X No Specify: White Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: if Itam 27 Is marked other then * Elementery/Secondary (0-12) College (1-4or 5+) Sales Salesman 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) Edwin M. Derrenberger, Sr. Florence E. McAleer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) permit. Pages 1 and 2 Depertment of Health a Important: if Itam 27 is any Injury or other tra Mrs. Doris L. Derrenberger (wife) 6304 White Cedar Court Eldersburg, MD 21784 altimore, 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🗷 Other (Specify) Enteriment Druid Ridge Mausoleum 1/13/98 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility HAIGHT FUNERAL HOME & CHAPEL (Box 195) man Hawall. Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** CARDIONLY GRATH SEVERAL CONGESTIVE /Medical Immediate Cause (Final disease or condition resulting in death) DOYS Examiner Due to (or es e consequence of) Examiner ettending physician and for use as the buriel-trensit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): P.O. 1 Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by to ATRIAL FIBRILLATIN; PERIPHERAL 1 Yes 2 No 3 Probably 4 Lunknown Records, VASCULAR DISEASE; STATUS PEST ETUDELEZETA 24b. Were autopsy findings available prior to completion of cause Completed 24a. Was en autopsy of death? Angue TATion RIGHT LIG teten 1 🗆 Yes 2 100 1 ☐ Yes 2 ☐ Ne Division of Vital certifice Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 After this in by the funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) Ne Hospital or Attending PI In 24 hours effer death. Ne Funeral Director: After the 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) end menner es stated.

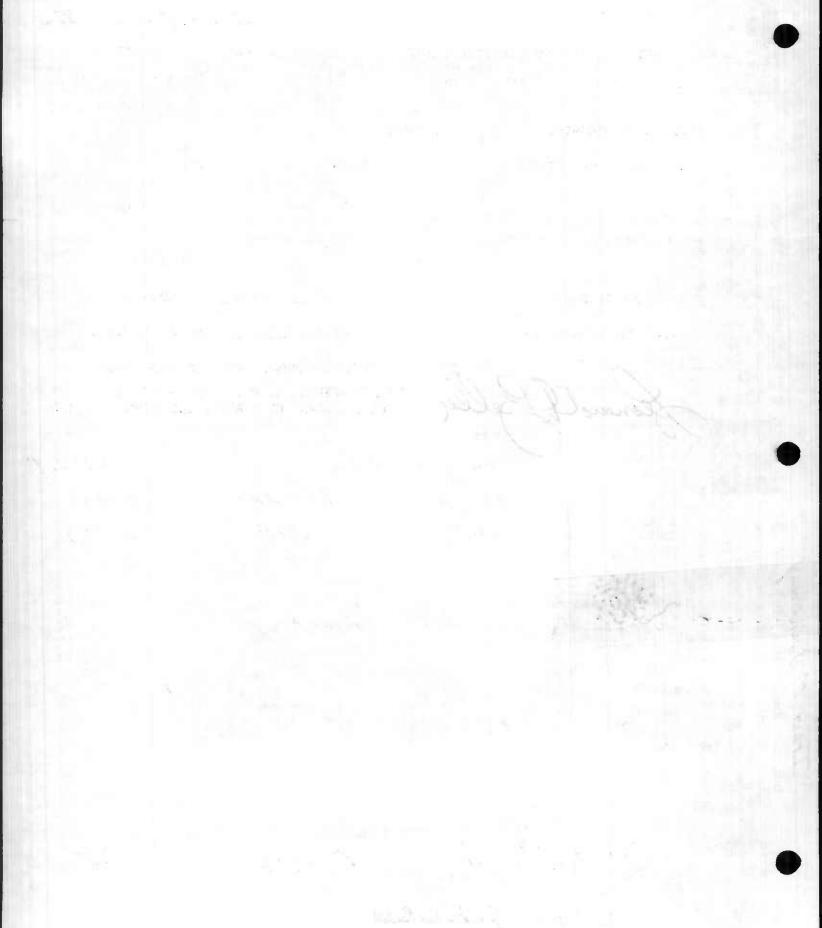
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only To the I 29d. Date signed (Month, Day, Yeer) 29b. Signeture and title of certil 29c. License number 018502 VANUAN, 10, 1998 (m) 30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print) PANDALISTONN med. 7-1133 B. CONTRAL ORIANDO My 31. Dete filed (Month, Day, Year) JAN 13 32. Registrar's Signature State

Registrar

commended the secondary of the forest

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydidnes

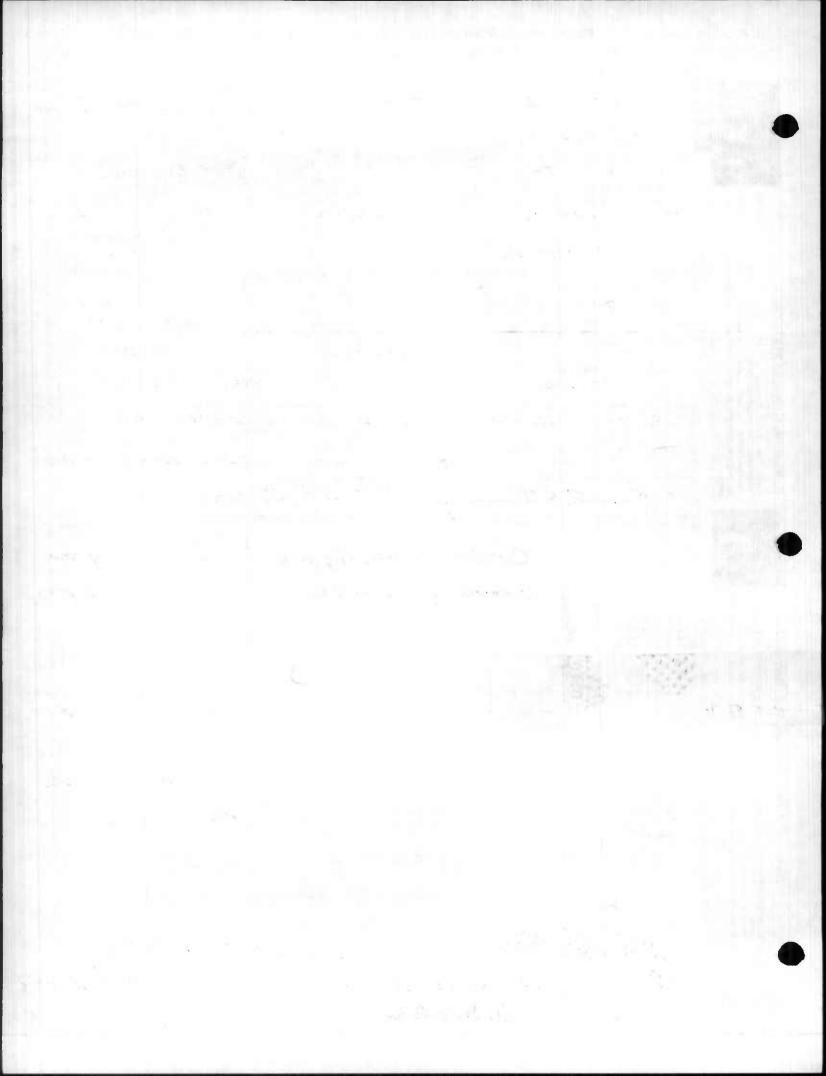
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ector		214-10-7069	1 □ M 2 🛣 F	78	Yrs.	Months Dey	s Hours Min.	FEB. 1	9, 1919	Countr MARYI	AND
	-	Usuel Residence of Decedent 10e. State 10b. County		100 Cit	y, Town or Loc					T.,	
1	5		70							100	d. Inside City Limits 1 XYes 2 No
Director	3	MARYLAND WICOMI 10e. Street end Number	CO	SAI	LISBURY				10- 00	10.110	
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		19e. Informent's Name/Relationshi JOANN JONES/DAU					et end Number or Ru				
	1	20e. Method of Disposition	GHIEK	20b. P	iece of Dispos	ition (Name of	ST AVENUE	, SALIS.	20c. Location -		
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0		27. Menner of Death 1. ANeturel 5 □ Pending	28e. Date of Inj (Month, D	ury ey Year)	28b. Time of Injury	28c. Inj	ury et ork?	28d. Describe	how injury occur	red	
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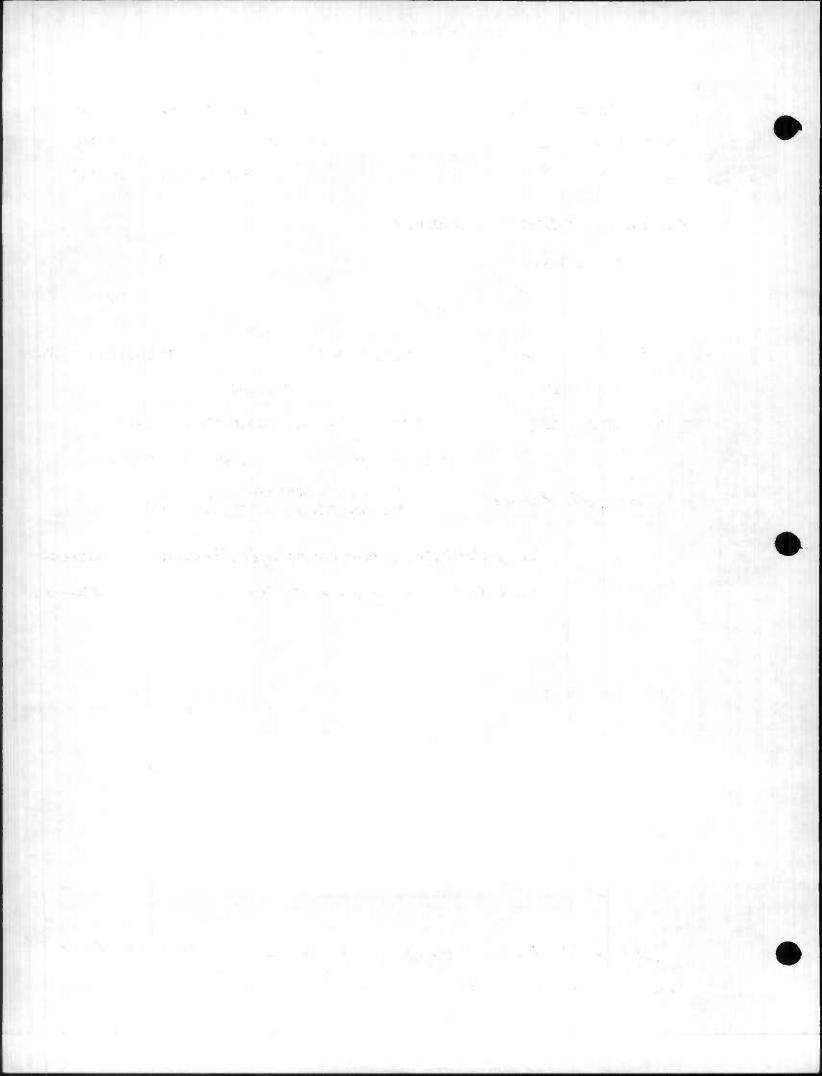
State of Maryland / Department of Health and Mental Hygiene 8 Certificate of Death 1. Decedent'e Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month CLARK 1998 HOWARD ELZEY January 16 /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Cambridge Dorchester 208 Meteor Ave. If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, July 23 5. Sociel Security Number 9. Birthplece (State or Foreign Country) Mary Land 7. Age (In yrs. lest birthday) **Funeral** MM 2DF 215-18-4967 Yrs. Director 1916 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or itams 23a or 28a-f show sny Injury or other traumatic event 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits Dorchester Cambridge Director Yes 2□ No 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? U.S.A. 21613 208 Meteor Ave. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 Yes ZINo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No 21215-0020 þ Specify: white 3 Widowed 4 Divorced Completed 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) contractor excavating Saltimore, Maryland 17, Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be Marcellus Kirwan Elzey Agnes 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 852 Hills Point Rd., Cambridge MD 21613 H. Clark Elzey, Jr. - son 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dunal 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 1-21-1998 Cambridge, Maryland Green Lawn Cemetery 21. Signature of Scherel Service Licenses 22. Name end Address of Fecility. Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) e. CARCIAC ARRAY thy MIA Examiner Examiner Generalized ASCVA I or Attanding Physician: The lew requires that the death certificate be executed after death. Director: After this certificate hes been signed t_Y the ettending physician and the burial-transit Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Box 68760, Physician/Medical Due to (or as e consequence of) for use Pert Ii. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. be detached 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown by 24b. Were eutopsy findings evellable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 Yes 2 His 1 ☐ Yes 2 ☐ No completely filled in by the funerel director, 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dev Year) 28c. Injury et Work? 1 Naturel 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier (Check only one) 1 Certifying Phyelclen: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

Sequence: On the best of exeminetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end manner steted. Medical 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month **Physician** JAN. 9 1998 GASTON C. FINNEY 5:10 pm /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Daath Examiner 36 LINCOLN PARKWAY ANNAPOLIS ANNE ARUNDEL If Under 1 If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Year 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foraign Country) **Funeral** Days Months 10 M 2 F Yrs. Director 223-22-3476 MAY 30 1926 VIRGINIA Usual Rasidance of Dacadent the Maryland show 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2 No Director 28a-f MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Straat and Number 10f. Zip Coda 10g. Citizan of Whet Country? 6 items 23a death Funeral 36 LINCOLN PARKWAY 21401 12. Was Decedant Evar In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Bleck, Whita, atc. should be filed within 72 hours effer and Mental Hygiene. marked other than "neturel", or ite Nas 2□No If Yas, Giva Yaar or Datas: 1945-46 1 Nevar Marriad 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Spacify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highest grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th EXTENSION AGENT UNIVERSITY OF MARYLAND 6th Pages 1 and 2 should be fill ment of Health end Mental Hight 1 ant: If item 27 is marked oth 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be MATTHEW FINNEY SUSIE MOORE 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) permit. Pages 1 and 2 s Department of Health er Important: If item 27 is any injury or other trau HANNAH FINNEY (WIFE) 36 LINCOLN PARKWAY ANNAPOLIS, MD. 21401 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, crematory or other place) 20c. Location - City or Town, Steta 1 ☐ Burial 2☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 1/12/98 BALTIMORE, MD. 21. Signature of Funaral Service Licensaa 22. Nama and Addrass of Facility WM. REESE & SONS MORTUARY, P.A. Lan 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, 21401 shock, or heart failure. List only one cause on each line. Approximata Intarval Batw Onsat and Death Physician /Medical Immediata Ceusa (Final a Chronic Degenerative heurologic disease
Dua to for es e consequence of): disaasa or condition resulting in daath) Examiner Physiclan/Medical Examiner Costico-basal degenera The law requires that the death certificate be executed physician and sthe buriel-trans Sequentially list conditions, if eny, laading to immediata ceuse. Enter Undarlying Ceuse (Disaasa or injury that Initiated avants rasulting in death) Last Dua to (or es a consequance of) Box 68760. Dua to (or as a consequance of): use es for u signed by the e P.O. Part II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Records, þ Be Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? complation of ceuse of death? page 2 1 Yas 2 1 No certificate 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physicien: 25. Was cesa refarrad to medical axaminar? director 26. Place of Death (Check only one) Hospital: Othar: 4 Nursing Homa 5 ■ AasIdance 6 Othar (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Deeth 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred After 1 Naturel 5 Panding invastigation death. 1 Yas 2 No ector: / 2 Accident 6 Could not be daterminad 3 Suicida in by t 28f. Location (Street and Number or Rural Routa Numbar, City or Town, Stata) 28a. Plece of Injury - At homa, farm, streat, fectory, offica building, etc. (Spacify) ofter 4 Homicide To the Hospital of within 24 hours of To the Funeral Completely filled 1 Certifying Physician: To the best of my knowladga, death occurred et the time, dete and place, and due to the ceuse(s) end mannar as stated.
2 Medical Examiner: On the basis of axaminetion end/or investigetion, in my opinion, death occurred at tha tima, date and place, end due to the causa(s) and manner stetad. edical 29a. Cartifiar (Check only onel 29b. Sopatura and titla of certifian 29c. Licansa number 29d. Data signad (Month, Day, Year) omplatad ceuse of death (Itam 23a) (Type, Print) hed. Parkway Annapolis MD 21401 MM 2003 32. Registrar's Signatura 31. Dete filad (Month, Day, JAN 1 3 1998 State Registrar



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	Physic /Medi	cal		1 Robert Fr	ohing FROHRI	NG	th City Town or I	Month January	-	Year 1998	8:22PM
1	Examii	ner	4a. Facility Name (If not institution,				4b. City, Town, or L		4c. County	of Death	
			972 Melvin Ro				Annapoli			Arun	
	Funeral Director		5. Social Security Number 271-09-9814 Usual Residence of Decedant	1X M 2∏ F	(In yrs. last birthday) 94 Yrs.	If Under 1 Yea Months Days		8. Date of Birth (Month, Day Aug 2 1	(Year) 903	9. Birthpl Coun. Ohi	ace (Stata or Foraig try) O
	B		10a. Stale 10b. County		10c. City, Town or Lo	cation				11	Od. Inside City Limits
	a-f sho	Director	Ohio Cuyaho	ga		grin Fal	.1s				1 ☐ Yes 2 XNo
4	138	je je	10e. Street and Number 7630	Chagrin Ro	ad	10f. Zlp Code		1	0g. Citizan ot	What Coun	try?
1	38.0		7630 Rainbridg	e Poad	o u	4	4022		Unite	d Sta	tes
		Jera	11. Marital Status	12. Was Decedent B	Ever in U,S. 13. V			pecify Yes or No-		a - America	
	our nous arec death with the maryland "naturel", or frame 23a or 28a-f show ad cal Examiner mark to notified at	by Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces?	lo II	f Yes, specify Cu I □ Yas 2万No	Hispanic Origin? (Sp ban, Mexicen, Puarto Specify:	Rican, atc.)	Specif	ck, White, e y: W	hite
man yiang a rail o	atr.		15. Decedent's	Education	16a. Deced	lant's Usual Occu	upation		16b. Kind of B	usinass/inc	lustry
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	2 2 2	E	Elementary/Secondary (0-12)	College (1-4or 5-	+)	ical Eng			Chemi	0.01	
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	a p a	Be					1000000			ech.	
	h and Mante	2	William Frohri					ha Louis			
	0 0 0		19a. informant's Name/Ralationship	(Type, Print)	19b. Mallin	g Address (Stree	et and Number or Ru	ral Routa Number	r, City or Town,	State, Zip	Coda)
	- N L		Paula F. Kushla	n (Daughter) 972	Melvin F	Road Annap	olis, Ma	ryland	2140	3
			20a. Method of Disposition	□Da===== 4==== 01=1=	20b. Place of Dispos cematary, cran	sition (Nama of natory or other pl	ace)	Date	20c. Location	- City or To	wn, Stata
	nent of h		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Evergreen	n Hills	Cemetery	1/18/98	Chagrin	n Fal	ls. Ohio
	Department of Important: If I any Injury or once.		21. Signature of Funeral Sarvice Lic	Pensee DO	22	. Name and Addi	ress of Facility Joh	n M. Tay	lor Fu	neral	Home, In
			23a. Part1. Enter the disease, or co shock, or heart tailure. List or	lowell	14	+/ Duke	of Glouce	ster St.	Annapo	olis,	MD 21401 Approximate Interval Between
State by specified	physician and strength strengt	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Hy	pertes in perten in pertes in pertes in pertes in pertes in perten in perten in pertes in perten	uance of):					syears Zyears
doubt partie	ding se esu	Physician/Me		d							
of the	the d	ysic	Part II. Other significant conditions	contributing to death bu	t not resulting in the un	nderlying cause g	iven in Part t.	23b. Did to	bacco use co	ntributs to	the cause of death
		by Ph				· · · · · · · · · · · · · · · · · · ·		1 🗆 Y	98 2 No	3 Prob	ably 4 Unknow
alelan: The law requires	20 00	Completed I						24a. Was a perform		ava	ra autopsy tindings ilable prior to nplation ot ceusa leath?
The	- 5	E						1 □ Ye	es XX No	1 -	Yas 2□ No
è	certificate rector, pa		25. Was case retarrad to medical				26 Pinns of Dan				
aloie	s certific director,	o Be	examiner?	Hospital:	аП ====	0		th (Check only on		- 1-	170
Phys.	h. After thi funeral	tlon: To	1 Yes 2 No 27. Manner of Death 1. Natural 5 Pending 2 Accident Invastigat	28a. Date of tnjun (Month, Day	nt 2 ER/Outpatiant y 28b. Time of Injury	28c. Inju	4 ☐ Nursing Heury at ork?	ome 5 ☐ Raside 28d. Describe ho			Daughters Home
or Attending	= 5 =	Certification:	3 Suicide 6 Could not determine	be an Diago of India	ry - At home, tarm, stre (Specify)	eet, tactory, office)	28f. Location (St City or Town		ber or Rure	l Routa Number,
e Hoenitei	within 24 hours effective the Funeral Director completely filled in	edical (29a. Cartifier (Check only one) Certifying I	Physician: To the best of aminer: On the basis of and manner state	examination and/or inv	occurred at the t estigation, in my	time, date and placa, opinion, death occur	and due to the cored at the tima, d	ause(s) and ma ate and place,	annar as st and due to	ated. tha ceuse(s)
Tothe	o th	Me	200. Signature and 100 of certifier	-/ -		29c. Licar	nsa number	2	9d. Data signe	d (Month, L	Day, Year)
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5	_		1 1000	, acces	MID		1017		Januar	у 15,	1998
			Matthew Malta,		Forest Dr		apolis, M	aryland	21401 (4	10-26	63-0770)
	Sta Registr		31. Date filed (Month, Day, Year)	6 1998 A S	re Signature Ruke Davidson	70 . e. oo					

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** ess18 /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner If Under 24 Hrs. 8. Date of Birth Month, Dey, If Under 1 Year 6. Sex 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State of Foreign Country) Gallipolis **Funeral** Months Deys 1□ M 2X) F 68 Yrs. 274-24-9305 Director January 14,1929 Ohio Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10e, Stete 10b. County 28a-f show 10d. Inside City Limits Examiner must be notified at Director TY Yes 2 No Ohio Montgomery Dayton 10e. Street end Number 10f. Zip Code 10g. Citlzen ot Whet Country? United States 6 228 Ardmore Avenue 45417 items 23a death Funeral of America 12. Wes Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2월 No It Yes, Give Yeer or Detes: 14. Raca - American Indian, Bleck, White, etc. 11. Marital Status 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) d 2 should be filed within 72 hours after the and Mantal Hygiene.
77 is marked other than "natural", or ite traumatic event, tra Modical Evanance. 1 Never Married X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify by 3 ☐ Widowed 4 ☐ Divorced Specify: Black. Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Supply Technician Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Pages 1 and 2 should be and Cantal and Mantal Harry W. Shockley Cloradean M. Smith 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) nt of Heelth a : If item 27 is r or other tra Bascom Graham/ Husband 228 Ardmore Avenue, Dayton, Ohio 45417 20b. Placa of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete January 1 X Buriel 2 Cremation 3 Removel from State permit. Page Department of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Dayton National 15, 1998 Dayton, Ohio 21. Signature of Funerel Servica Licansee #M00690 22. Name end Address of Fecility
Thomas Funeral Home 3701 West Third Street, Dayton, Ohio 45417 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heert tailure. List only one ceuse on each line. Approximate Intervel Between Onset end Death Physician /Medical Immediate Ceuse (Finel Budenemia 5 diseese or condition resulting in deeth) d Examiner Due to (or es e consequenca of): Examiner UROSEPSIS The law requires that the deeth certificate be executed buriel-transi Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Lest Due to (or es e consequence ot): Ble P.O. Box 68760. 20 Physician/Medical tha Due to (or es e consequence et): 98 for use Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. dateched 23b. Did tobacco use contribute to the cause of death? ils cartificate has bean signed by director, paga 2 should be dated 1 Yes 2 No 3 Probably 4 Unknown . p. n. M Records, by Completed 24b. Were eutopsy tindings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attanding Physician: Be 25. Was case reterred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No Inpatient 2 □ ER/Outpetient 3 □ DOA this funaral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftart Division 1XXIatural 5 Pending investigation To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completaly filled in by tha fun 1 | Yes 2 | No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29e. Certifier Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner es steted.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end placa, end due to the cause(s) end menner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 045365 11701 LIVINGSTEN FORT WAShington 30. Name end eddress of person who completed cause ot deeth (Item 23a) (Type, Print)

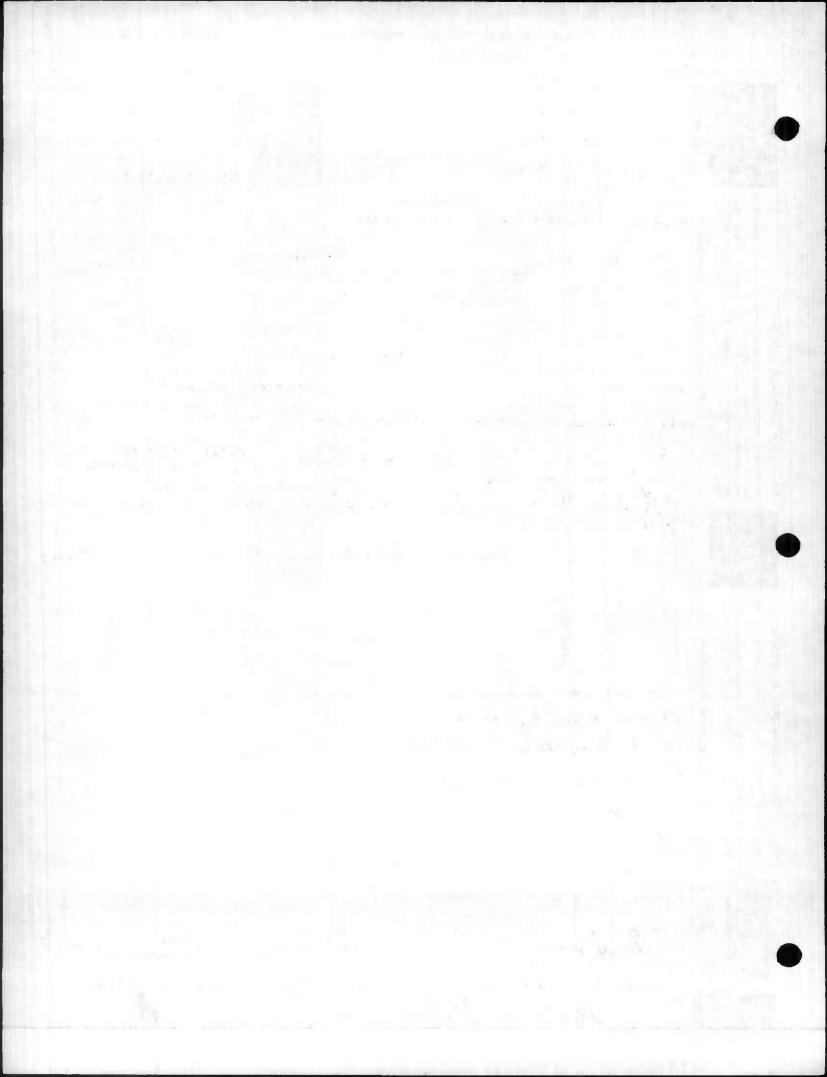
32. Registrar's Signature

State Registrar 31. Dete tiled (Month, Day, Yeer)

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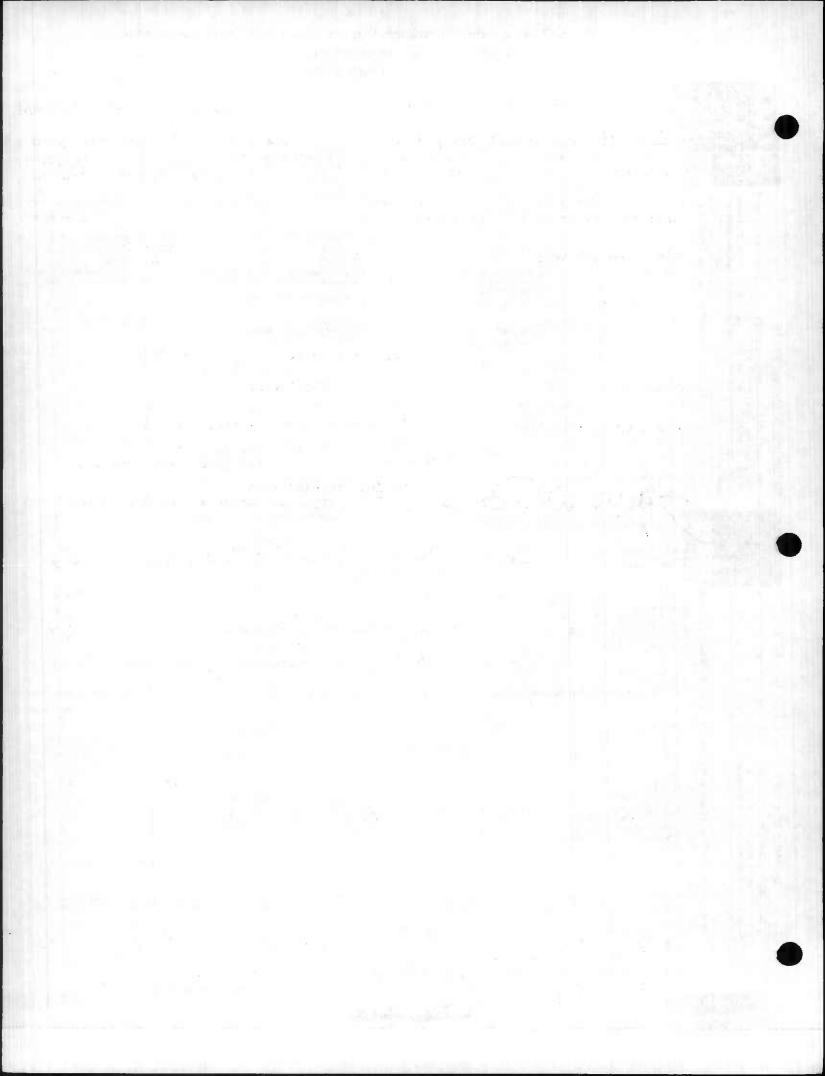
State of Maryland / Department of Health and Mental Hygiene

					Certifica	te of		P	eg. No.	UZ	1107
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Funeral Director		5. Social Security Number 189–26–4883 Usual Rasidanca of Decedent	6. Sax 1 M 2 □ F 90	a (in yrs. lest l	Yrs. If Und Month	er 1 Year s Days		. (Month, Day	Year) r 15,19	9. Birthple Count 07 Pe	aca (Stata or Foraig ry) nnsylvani
and **		10a. Stata 10b. County		10c. City, To	wn or Location					10	d. Insida City Limits
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4 vithin 72 hours after death with the Manyland jiens. I than "natural", or Items 23s or 28s-f show the Moodel Examine must be notified at	by Funeral	11. Marital Status 1 □ Never Merried 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	12. Wes Decedent II Armed Forcas? 1 X Yas 2 N If Yas, Giva Yaar or Datas:				Hispanic Origin? (- ean, Maxican, Pua Specify:	Specify Yas or No- rto Rican, atc.)		ea - Amarica ck, White, a	tc.
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a la la	To Be	John Grace	131/					et Reddin		10)	
Mal yial d2 should by h and Menta 7 is marked traumatic ev	-	19a. Informent's Name/Ralationsh	p (Type, Print)	15	9b. Mailing Addra	ss (Stree	t end Number or F	lural Routa Number	, City or Town.	Stete, Zip (Code)
nd 2 salth ar		Mary Therese Cla	rk/ Daughter					Rockvill			
permit. Pagas 1 and 2 Department of Health a Important: If Item 27 is any injury or other train		20a. Mathod of Disposition 1 Burial 2 □ Cramation 4 □ Donation 5 □ Othar (Sp		camat	of Disposition (Nary, cramatory of	othar pla	-	January 17, 1998	20c. Location - Pitts Penns	ton,	
mit.		21. Signature of Funaral Service L			22. Name	and Addre	ess of Facility			yivan	<u>ra</u>
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cartific complataly filled in by the funeral director.	edical C	29a. Cartifiar (Check only one) 1 CertifyIng 2 Medical E	Physician: To the best o kaminar: On the basis of and manner sta	examination a	ga, daath occurre and/or invastigation	d at tha ti on, in my o	me, date end plec opinion, daath occ	e, end due to the c urred at tha tima, d	euse(s) end ma ata and placa,	anner as ste and dua to	ited. the cause(s)
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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 98 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Dey HERSCHEL McQUAY GLOVER 9, 5:37 PM 1998 JAN. 4b, City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) WESTMINSTER CARROLL COUNTY GENERAL HOSPITAL CARROLL 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number Birthplace (State or Foreign Country) Deys 1 X M 2 □ F 7/23/1917 217-12-1625 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits CARROLL WESTMINSTER 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21157 USA 2347 OLD WASHINGTON RD. 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WW II 14. Raca - American Indien. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 M Married 1 ☐ Yes 2 № No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) CONSTRUCTION CARPENTER 6 18 Mother's Name (First Middle Maiden Surneme) 17. Father's Name (First, Middle, Last) GEORGE SAMUEL GLOVER ESTELLA CARRIE McQUAY 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code), 1 1 5 7 19a. Informant's Name/Relationship (Type, Print) 2347 OLD WASHINGTON RD., WESTMINSTER, MD. ALVERTA A. GLOVER - WIFE 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremetion 3 Removal from State ZION U.M.CHURCH CEM. 1/13/98 WESTMINSTER, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility FLETCHER FUNERAL HOME 21. Signature of Fungial Service 254 E. MAIN ST., WESTMINSTER, MD. 21157 1001 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) ENTRICULAL FIBRILLATION Due to (or es e consequence of). Due to (or es e consequence of) 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown

Physician /wedical Examiner

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director

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filled in Hospital 24 hours 24 hours Funeral

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Certification:

Medical

Attending Physician:

i or Attendin efter death. Director: Aft

To the Hosp within 24 ho To the Fune completely fi

the death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Examination must be notified at

other

= 0 permit. Page Depertment of Important: If any Injury or

Pages 1 end 2 should be filed within 72 hours aftar death with it tent of Health and Mentel Hygiene. nt: if Item 27 is marked other than "natural", or items 23s or?

Baltimore, Maryland 21215-0020

the Meryland

/Medical

10e State

MD.

Director

Funeral

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Completed

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Examiner Physiclan/Medical á

Completed 25. Was cese referred to medical examiner? Be

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

1 Yes 2 No

27. Menner of Death

1 Awaturel

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

24b. Were eutopsy findings evailable prior to 24a. Was an autopsy performed? completion of cause of death?

1 Yes 2 LN 1 ☐ Yes 2 ☐ No 26. Piece of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es steted. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier Repanys

D18200

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700-A POLERO WESTMINSTER HD 2115

State Registrar 31. Date filed (Month, Day, Year) JAN13

5 Pending

investigation

6 Could not be determined

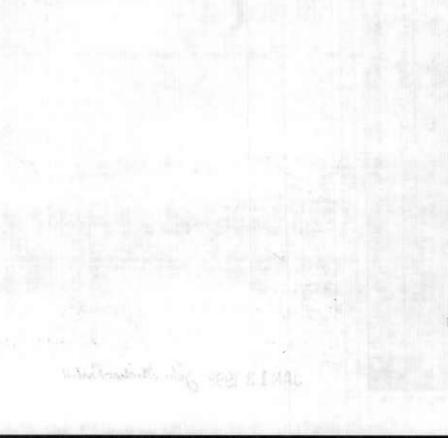


Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

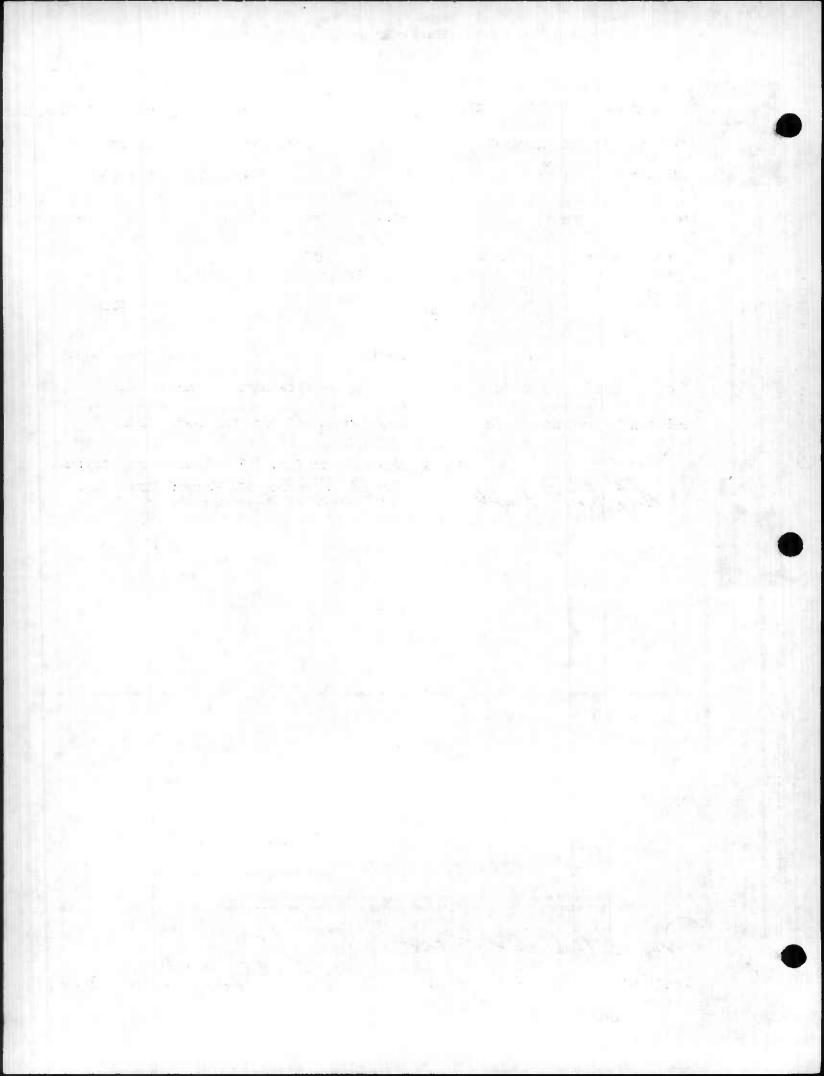
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Dey Year)



			State of Mary		ertificate of			i. No.	12110
Physic /Medi	cal	Decedent's Name (First, Middle, Lasi JOSEPH FRAI Facility Nema (If not institution, giva	NCIS GUE	RCIO		4b. City, Town, or Lo		Dey Yaar 11, 1998 4c. County of Daeti	3. Time of Death 1:15 A.M
Funeral Director		Fallston General 1 5. Social Security Number 6. Se 217-24-5363	Hospital	n yrs. last birthda 69 Yrs.	y) If Under 1 Year Months Deys	Fallsto		Harfor	
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with the Marylend as or 28a-f show	i Director	10e. Street end Number 5 Dixie Drive	SIG		10f. Zip Code	21014	100	. Citizen of Whet Co	
5-0020 72 hours efter death neturel; or items 23	by Funeral	11. Maritel Status 1 Naver Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Eve Armad Forces? 1 XYas 2 No If Yes, Give Yeer or Datas: 19			Hispanic Origin? (Spe ean, Mexican, Puarto	ocify Yas or No- Ricen, atc.)	14. Race - Amai Black, White	
21215-0020 within 72 hours effe ene. then "neture!, or it he wed cell Exercise.	To Be Completed	15. Decedent's Edu (Specify only highest grad Elementery/Secondery (0-12)	cation	16a. Dec (Gir life.	edant's Usual Occu re kind of work dona DO NOT usa retire	petion during most of working)	ng	b. Kind of Business/I	ndustry
/land 2 /land 2 /land be filed //ental Hygi	To Be Co	17. Fethar's Name (First, Middle, Last) Paul (nmn)	Guercio	ACC	Courteant	18. Mother's Neme	(First, Middle, Ma	iden Surname)	
Baltimore, Maryland 21215-0020 permit. Pages 1 end 2 should be filed within 72 hours effer death with the Maryle Department of Health and Mental hygiene. Important: If Hem 27 is marked other than "naturel", or Hema 23s or 28s-4 show any injury or other treumatic event, the Medical Exercitive matter notified at once.		19e. Informent's Name/Reletionship (T) Rebecca W. Guerci 20a. Method of Disposition 1⊠ Burial 2 □ Cremetion 3 □ F 4 □ Donetion 5 □ Othar (Specify) 21. Signature of Funeral Service Licens	o - Wife	5 Di 20b. Plece of Dis cemetery, cr	ixie Drive position (Neme of emetory or other ple atius Chur 22 Name and Addre	rch Cem. 1	, Maryla Dete 20 -14-98	nd 21014 c. Location - City or I Hickory, N	fown, Stete Maryland
Physician Medical Examiner Medical Examiner political physician and political physician an	/Medical Examiner	23e. Part1. Entering disease, or complishock, or heart feilure. List only of the second secon	Due		equence of):	NG CA			intervel Between Onset end Deeth
P.O. B let the death d by the ette	ed by Physician/M	Pert II. Other significant conditions con	tributing to death but no	ot rasulting In the	underlying ceuse gi	ven in Part I.	23b. Did tobs 1 Yes	2 No 3 Pro	to the cause of death? bably 4 Unknown Vere eutopsy findings
100 0 - 6	Completed						performe	Co	vellable prior to ompletion of causa f deeth?
On of Vita ding Physicien: h. After this certific funeral director,	Certification: To Be C	25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Heturel 5 Pending Investigation 3 Sulcide 6 Could not be determined	28e. Place of Injury building, etc. (S)	At home, farm, s	of 28c. Injur	y at rk? Yes 2 \sum No	ne 5□ Rasidenc 8d. Describe how	e 6 □Other (Specinjury occurred	ify)
Divisi To the Hospital or Attenwithin 24 hours effected at 70 the Funeral Director.	Medical Ce	29e. Certifier (Check only 2 Medical Examination) 29b. Signature end title of certifier	Ician: To the best of my ler: On the bests of examend menner steted.	r knowledge, dee minetion end/or i	th occurred et the time the ti	pinion, deeth occurre	d at tha time, dete	ee(s) end menner es end plece, end due Date signed (Month	to the ceuse(s)
1241	te	30 Name and eddress of person who co	mpleted ceuse of deeth JAVA) 5 32. Registigar's S	m)	Print) 31/2	STON ,	MARY	LANS	2047



Please Type or Print in Black Il Gelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Dey Lucille Beatrice Gambill January 8, 3:15 PM 1998 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 2108 White House Road Bel Air If Under 24 Hrs. Hours Min. Harford If Under 1 Year 7. Age (in yrs. last birthday) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Months Days 1 M 28 F Yrs Director 220-46-2609 81 Aug. 21, 1916 North Carolina Usuel Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Harford Bel Air 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 234 2108 White House Road 21015 USA permit. Pages 1 end 2 should be filed within 72 hours efter death v. Department of Health end Mentel Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23s any injury or other traumstic event. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Yes 2X No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 21 No Specify: þ 3₺ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Samuel Denson Poplin 2 Jettie Ethel Gambill 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Gwyndolyn G. Poole, 2133 White House Road, Bel Air, Maryland Niece 20b. Place of Disposition (Name of cometery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State Bel Air Memorial Gardens 1/12/98 Bel Air, Maryland 4 Donation 5 Other (Specify) 22. Name end Address of Fecility Howard K. McComas III Funeral Home, P.A. Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximate Approximate Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in death) ASCVD Examiner Due to (or es e consequence of): Physician/Medical Examiner physician end the buriel-transit the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760 Due to (or es e consequence of): 80 attending 980 for ed by the a Division of Vital Records, P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2X No 3 Probably 4 Unknown Diabetes Mellitus II signed t þ should 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Was en eutopsy performed? pege 2 1 Yes 2 No 1 ☐ Yes 2 No certificate i or Attanding Physician: efter death. Director: After this certifice Be 25. Wes case referred to medical exeminer? 28. Piece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 8 ☐ Other (Specify) Certification: To Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funerai 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending 1 Naturel 1 ☐ Yes 2 No investigetion NA NA 2 Accident NA 6 Could not be determined n 24 hours efter des ne Funeral Director pletely filled in by th 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide NA Hospitai 29e. Certifier Medical 1 Certifying Phyelcien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated. (Check only one) 29b. Signature and title of certifier 29c. License number DME OCME 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

218 Fulford Ave., Bel Air, Maryland

Whi Davelson Randall

32. Registrer's Signeture

21014

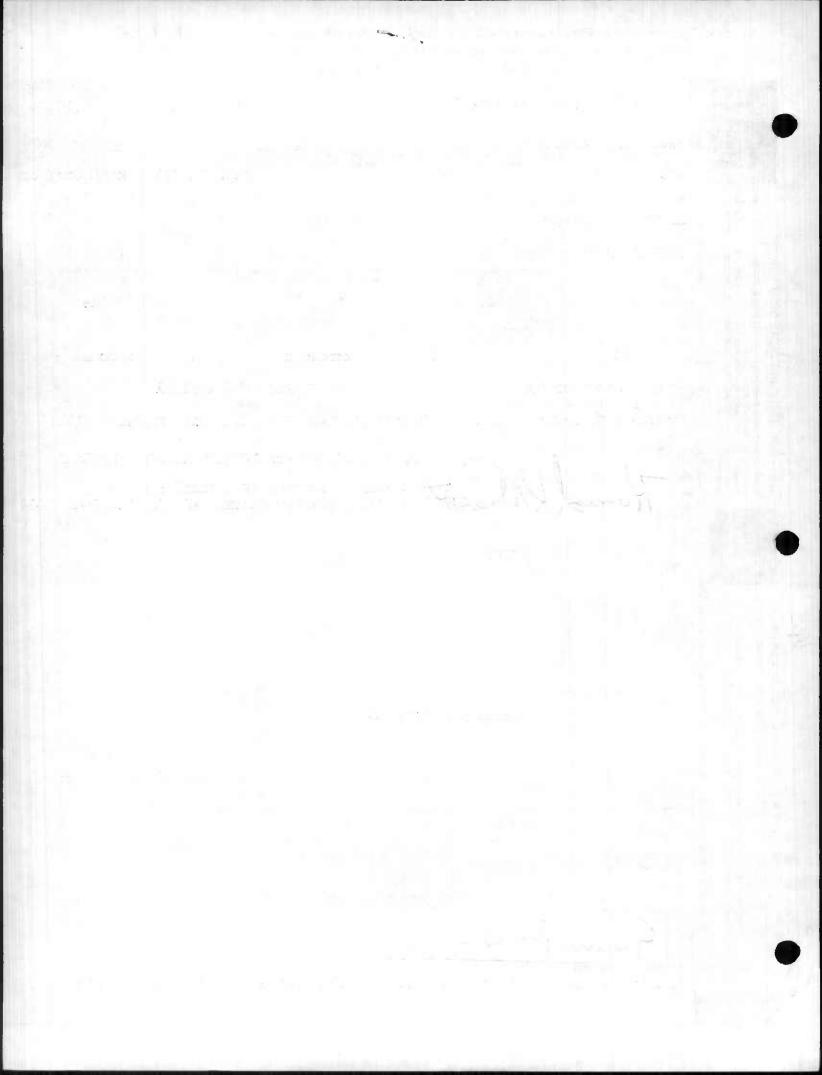
DHMH 16 Rev 6/95

State

Registrar

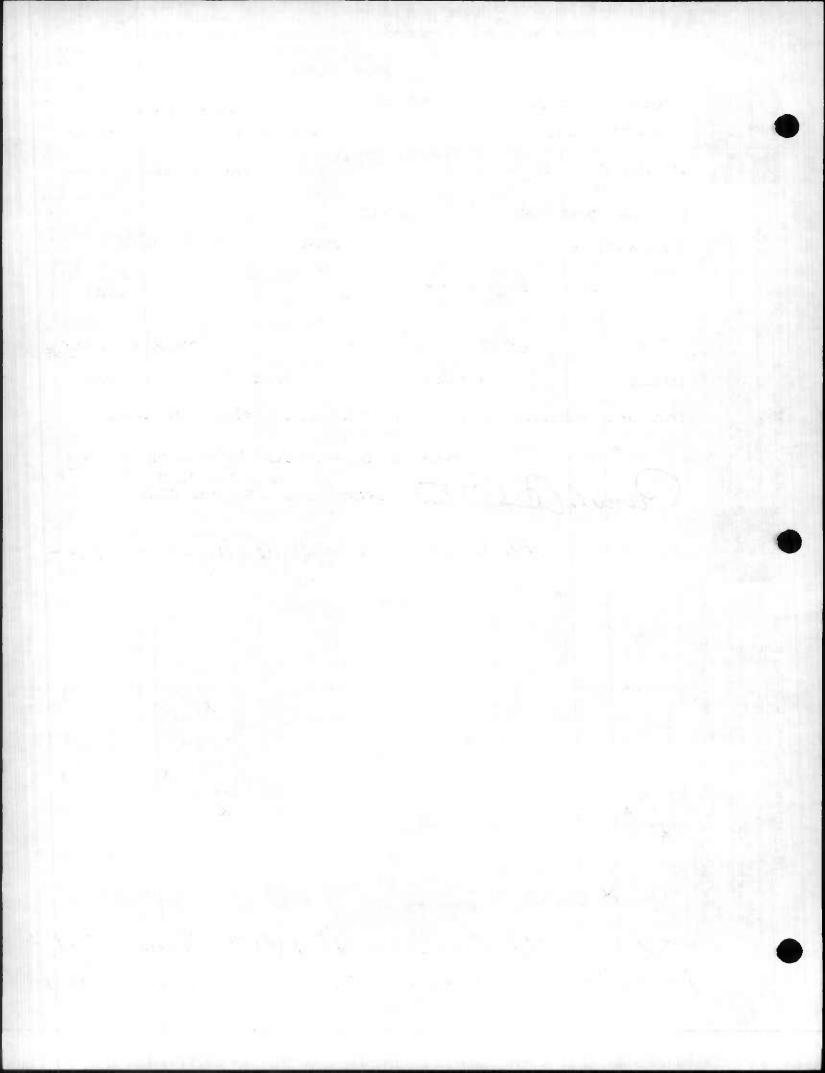
G.S. Prabhu M.D.

31. Date filed (Month, Day, Year)

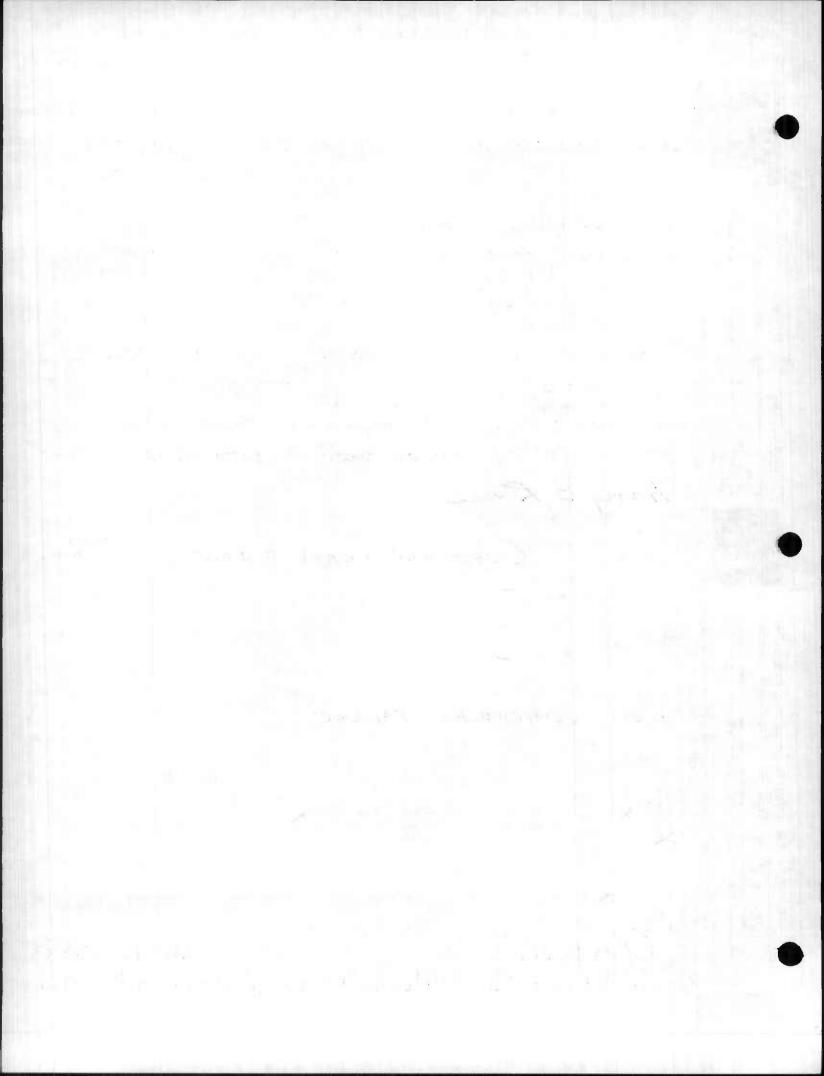


State of Maryland / Department of Health and Mental Hygiene 8 02 1 2

			Decedent's Name (First, Middle, Las	it)		Certific	ate of	Death	2. Dete of Deet	g. No.	3. Time of	Death
	Physic /Medi		KENNETH PHIL	IP	HAEGI	ERICH			Month JANUARY	_{Dey} 7, 199	Year	
4	Exami		4e. Fecility Name (If not institution, giva 6 FERNDALE AVENUE	street end number)				4b. City, Town, or GLEN BUF		4c. County		
Г	Funeral Director		5. Social Security Number 6. Se 213-14-9768	9x 7. Age (I.	n yrs. lest birth 75 Y	nday) If Un Monti	nder 1 Year hs Deys	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, MAR . 25	, 1922	9. Birthplece (State of Country) MARYLAND	r Foreign
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND QUEEN		oc. City, Town	or Location	SVILLI	G			10d. Inside Ci 1 ☐ Yes	
	3a or 28	Il Director	10e. Street end Number 111 OAK STREET			10f.	Zip Code 2	666	10	og. Citizen of W	het Country?	
020	within 72 hours efter deeth with the Maryland ilene. Then "natural", or items 23s or 28s-f show the Medical Examinar must be notified at	by Funeral	11. Meritel Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates:	1943- 1946			Hispanic Origin? (S en, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		- Americen Indien, c, White, etc. WHITE	
5-0	72 ho	eted	15. Dacedant's Edi (Specify only highest gred		16a. I	Decedant's U (Give kind of	Jsual Occu work done	pation during most of world)	rking	6b. Kind of Bu	sinass/Industry	
121	filed within Hygiene. ther than	Completed	Elamantary/Secondary (0-12)	Collega (1-4or 5+) N/A		life. DO NO ACHINI		d)		OSEPH I	E. SEAGRAM	. &
Maryland 21215-0020	be filed tal Hyg d other	Be	17. Fether's Neme (First, Middle, Last) CHARLES		GERICH			18. Mothar's Nar	me (First, Middle, M	leiden Surname	MOCK	NS, IN
Mary	PELS	To	19e. Informant's Name/Relationship (7)					end Number or Re EET, STEV				
Baltimore,	permit. Peges 1 and 1 Department of Health important: if itam 27 any Injury or other troops.		20a. Method of Disposition 1 Burlal 2 A Cremetion 3 1 4 Donetton 5 Other (Specify, 21 Service License)	Removel from State)		EAKE C	or other pla	ORY, INC	1/14/98 NGLETON F	BELTSV:		61
	Deprivation of the property of	il Examiner	23a. Fart1. Enter the disease, or domp shock, or heart failure. List only commediate Ceusa (Final disease or condition resulting in death) Sequantially list conditions, if eny, leeding to immediate ceusa. Entar Underlying Ceusa (Disease or injury	o. Me fas	tek, a to (or es e co	ponsequence	of):	med/cell			Approximati Intervel Beh Onset end I	ween Deeth
x 68760,	certificate to ding physic se as the to	Medical	thet initiated events resulting in deeth) Last	Due	to (or es e co	onsequ <i>e</i> nce o	of):					
Box	deeth ce ettendir d for use	iciar	Pert II. Other significant conditions co	ntributing to death but n	ot resulting in	the underlyin	a cause oi	ven in Deet I	23h Didto	2000 Hee COD	tribute to the cause of	of death?
P.0	es that the de igned by the e be deteched t	y Physician/	Total agrinuant conditions co	Mindaling to death but h	ot resulting in	the underlyin	ig cause gi	ven in Pert I.	1 Y		3 Probably 4	
Division of Vital Records,	aw requi	Completed by							24e. Wes en		24b. Were eutopsy f evailable prior to completion of co of daeth?	0
a B	ate peg								1 □ Ye	s 2 No	1 □ Yes 20	Ño
<u>=</u>	Physician: The rthis certificate rail director, peg	o Be	25. Was cese referred to medicel examiner? 1 ☐ Yes 2 No	Hospital:	2 ☐ ER/Out	etient 2	DOA Ot	hoe:	oth (Check only one			
ion of	After fune	tion: To	27. Mannar of Deeth 1. Netural 5 Pending 2 Accidant investigetion	28e. Deta of Injury (Month, Day Ya			28c. Inju	4 Li Nursing F	28d. Describe ho	nce 6 □Othe w injury occurre		
Divis	al or Attendi s efter death il Director: A ed in by the f	Certification:	3 Sulcide 6 Could not be 4 Homicida determined	28e. Place of Injury building, atc. (5	- At homa, fari Specify)	m, street, fac	ctory, office		28f. Location (Str City or Town		or Aurel Route Num	ber,
	To the Hospital or Att within 24 hours efter of To the Funaral Direct completely filled in by	edical (29a. Certifier (Check only one) Certifying Phy	sician: To the best of milner: On the basis of exe end menner steted	amination end	daath occurr or Investigat	red et the ti tion, in my	ma, data and place opinion, death occu	, and due to the ce rred at tha tima, da	usa(s) and mar ta and place, e	nnar as stated. nd due to tha ceuse(s)
	To the within 2 To the comple	Me	29b. Signature end 15% of certifler	Make	espit.	2	29c. Licen	10			(Month, Dey, Year)	794
			30/Name end eddress of parson who co	ompleted cause of deeth	(Item 23e) (T	ype, Print)	Hial	16. 5.	600 6	L. R.	ry P.17 ie, Nd. 2100	61
	Sta Registi	-	31. Dete filed (Month, Day, Year)	320Registrar's	Signature	ndell	1	147) July	cove, o	ier our	ej will	7/



		_		State of Mar		Certificate				Reg. No.	UZ	113
	Physici /Medic Examir	cal	Decedant's Name (First, Middla, Last LORRAINE L. HA 4a. Facility Nema (If not institution, give	RRIED			4	b. City, Town, or Lo		Day 12 1998	Yaar of Death	3. Tima of Death 1:25 an
	Funeral Director		PLEASANT LIVING NU 5. Social Security Number 6. S 217-56-4077 Usual Rasidence of Dacedant		(In yrs. last birt			DGEWATER If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De OCT • 20	th y, Yaar)	ARUN 9. Birthple Countr IARYL	aca (Stata or Foreign
	Maryland f show	tor	10a. Stata 10b. County		Oc. City, Town						10	d. Inside City Limits
	n 72 hours efter deeth with the Maryland *natural*, or Items 23e or 28e-f show scient Examiner must be notified at	ral Director	MARYLAND ANNE AR 10a. Straet and Number 39 COLLEGE CREEK		ANNAPO	10f. Zip Co				10g. Citizen of W	/hat Counti	y?
020	urs efter de sl', or items	by Funeral	11. Marital Status 1 □ Never Marriad 2 □ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedant Even Armad Forcas? 1 ☐ Yas 2 ☒ No if Yas, Give Yaar or Datas:	ar in U,S.	13. Was Dacadan If Yas, specify 1 ☐ Yas 2 ☒		spanlc Origin? (Spa n, Mexican, Puarto Specify:	acify Yas or No Rican, atc.)		a - Amarica k, White, et BLA	tc.
121	within liene. Than	Completed	15. Decedant's Ed (Spacify only highast gra Elementery/Secondary (0-12) 8th			Decedant's Usual C (Giva kind of work of lifa. DO NOT usa i	lona d atired)	luring most of worki	ing	16b. Kind of Bu		
ng	should be filed and Mentel Hygis marked other umatic event, if	To Be C	17. Father's Nama (First, Middle, Last) JOHN W. HARRIE	D				18. Mothar's Nama	(First, Middle,		9)	
re, mar	T Is		19a. Informant's Name/Ralationship (7 SONYA J. THOMAS (20a. Mathod of Disposition	NEICE)	41 20b. Placa of	Mailing Addrass (S 5 KNOTTWO Disposition (Nama	OD of	COURT AR				
altimore,	it. Page intment o rtant: If njury or		1 Surial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specify 21. Signature of Funarai Sarvica Lican	Ramoval from Stata	camatar)	REST CEME	r place TEF	RY 1/	16/98	ANNAPOL		
ñ	Depe Impo any I		Harry 5. 23a. Part1. Enter tha disaasa, or compshock, or haart failura. List only	Plicetions that caused th					r respiretory a	rrast.	- !	Approximate
	Physician /Medical Examiner	Examiner	Immadiata Cause (Final disease or condition resulting in death) Saquantially list conditions, if any, leading to immadiate cause. Enter Underlying	a. COR	ONA/	2 Y 1+ Eonsaquanca of):						Intarval Batween Onsat and Daeth IANY YEARS
<	eath certricete be executed ettending physician end ifor use as the buriel-transit	edicai	cause. Enter Undarlying Causa (Diseasa or injury that initiated avants rasulting in death) Last	C. Du	a to (or as a co	onsaquanca of):						
	the the	Physician/M	Part II. Other aignificant conditions co	entributing to death but r	not rasulting in	tha undarlying caus	a giva	n in Part I.	23b. Dld	tobecco uae con	tribute to t	the ceuse of death?
-	requires seen sign hould be	by	LEFT VE	NTRICUL	AR	FAILU	2 E		1 🗆 24e. Wes	an autopsy	evei	a autopsy findings ieble prior to plation of cause
שנו וופר	Ine law ete hes page 2	Completed							1 🗆 '	Yes 2 No	of de	eeth? Yes 2□ No
UNISION	To the rospital or Attending Physician: In within 24 hours effer death. To the Funeral Director, Affer this certificate completely filled in by the funeral director, par	Certification: To Be	25. Was case rafarred to medical axaminar? 1 Yas 2 No 27. Mannar of Daath 1 Staturat 5 Pending investigation 3 Suicide 6 Could not be datarmined		- At homa, far	ima of 28c. jury M		at ?	ma 5□ Rask 28d. Dascribe	danca 6 Otha	ad	
	vithin 24 hours of To the Funeral I completely filled	edicai C	29a. Certifiar (Check only one) Certifying Phy	rsicien: To the best of miner: On the basis of ax and mannar stated	amination and	deeth occurred et to	ne tima my op	a, data and placa, a Inion, daath occurre	and dua to the ad et the time,	cause(s) end mar deta end place, e	nnar as sta nd due to t	tad. he cause(s)
j	To the comp	M	29b. Signature and title of certifiar	W. Ku	nu	29c. Li	cansa	number 928		29d. Data signed	(Month, D	ay, Year) 1998
	Sta Registr	-	30. Nama and addrass of person who of the control o	omplated causa of daat ER D 2 32. Registrar's	003M	EDICALDI	ζW	v,#100,	ANNA	POLIS, N	1D	21401



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3 Time of Death **Physician** Month 1998 WALTER EDWARD HARRISON, JR. JANUARY 12 /Medical 4e. Fecility Nama (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Deet Examiner GLEN BURNIE ANNE NORTH HRUNDEL HOSTITAL RUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** 1XXM 2□ F Months Country) MARYLAND Director Yrs. 217-20-3244 Usuel Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Madical Examiner must be nutrified at 1 ☐ Yes 2XNo Director MARYLAND ANNE ARUNDEL **GAMBRILLS** 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2640 APRIL DAWN WAY 21054 U.S.A. Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes ♣⑤ No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Rece - Amarican Indian, Bleck, White, etc. 1 Never Married Married 1 ☐ Yes 2 No P Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retirad) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and 2 should be filed within aalth end Mantai Hygiena. n 27 is merked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 N/a TRUCK DRIVER FOOD 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RRISON WALTER EDWARD HARRISON, SR. 2 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Separtment of Haalth er moortant: If Item 27 is GUY HARRISON/ SON 2640 APRIL DAWN WAY GAMBRILLS, MARYLAND 21054 20b. Place of Disposition (Neme of cemetery, cramatory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete XX Burial 2 Cremation 3 Ramoval from State GLEN HAVEN MEMORIAL PARK 1/15/98 GLEN BURNIE, MARYLAND 4 ☐ Donetion 5 ☐ Othar (Specify) A 22. Name end Address of Fecility SINGLETON FUNERAL HOME, P.A. 21. Signature of Furural S. GLEN BURNIE, MARYLAND 21061 1 SECOND AVE S.W. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one ceuse on each line. **Physician** Sepsis /Medical Impediate Cause (Final deate or condition resulting in death) Examiner Due to (or es e consequence of): Examiner ettending physicien and for use es the burlal-transit that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted evants rasulting in deeth) Lest ASTNOTATESTIME BLEEDING Dua to (or es e consequence of): Records, P.O. Box 68760. Physician/Medical OF CULAN DISCASE Part If. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown signed l by 24e. Wes en eutopsy performed? 24b. Were eutopsy findings evelleble prior to completion of causa of death? Completed peen has certificata 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this certifica completally filled in by the funeral director; 25. Was cese reterred to medicel exeminer? Be 26. Piece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Death 28b. Time of Injury 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? Medical Certification: 28d. Describe how Injury occurred 1 Naturel 2 Accident 5 Pending invastigation

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

who completed ceuse of deeth (Item 23e) (Type, Print)

32. Registrar's Signatura

Julia Davidson

1 Yes 2 No

NONTH ALUNDEL HOS

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, data end place, end due to the ceuse(s) and menner stated.

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State Registrar 6 Could not be determined

JAN 16

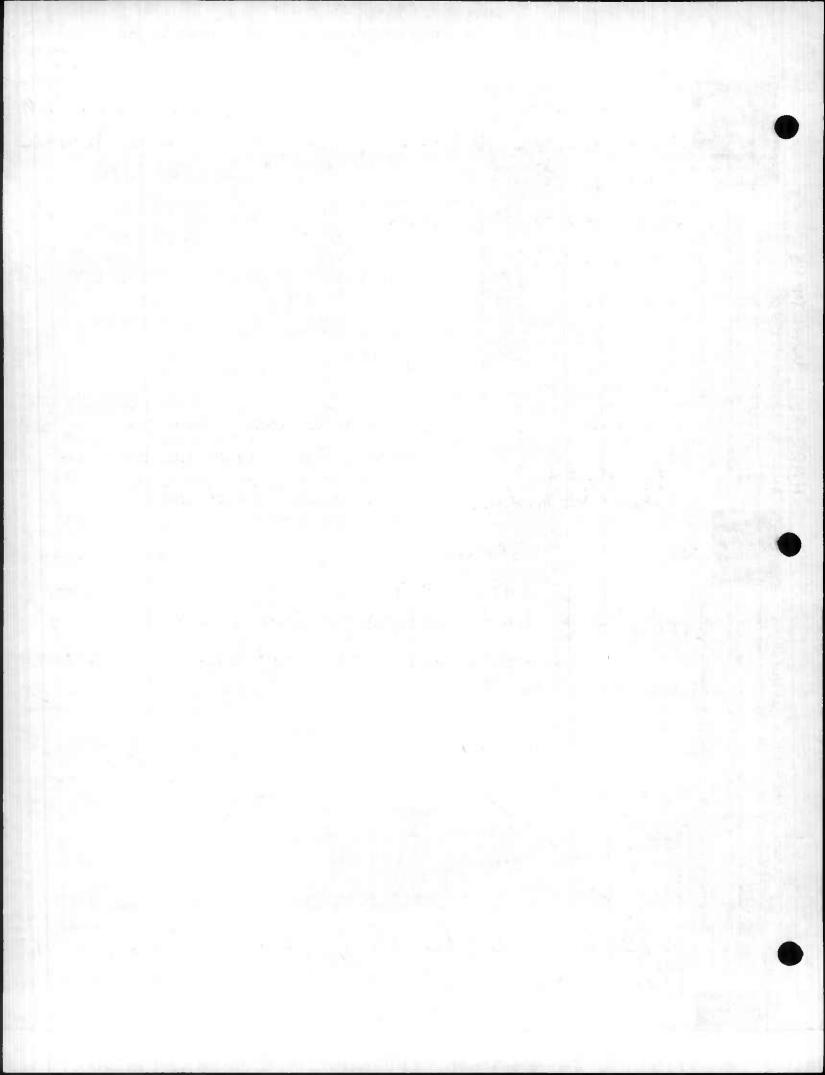
3 ☐ Sulcide

29a. Certifier

29b. Signatup

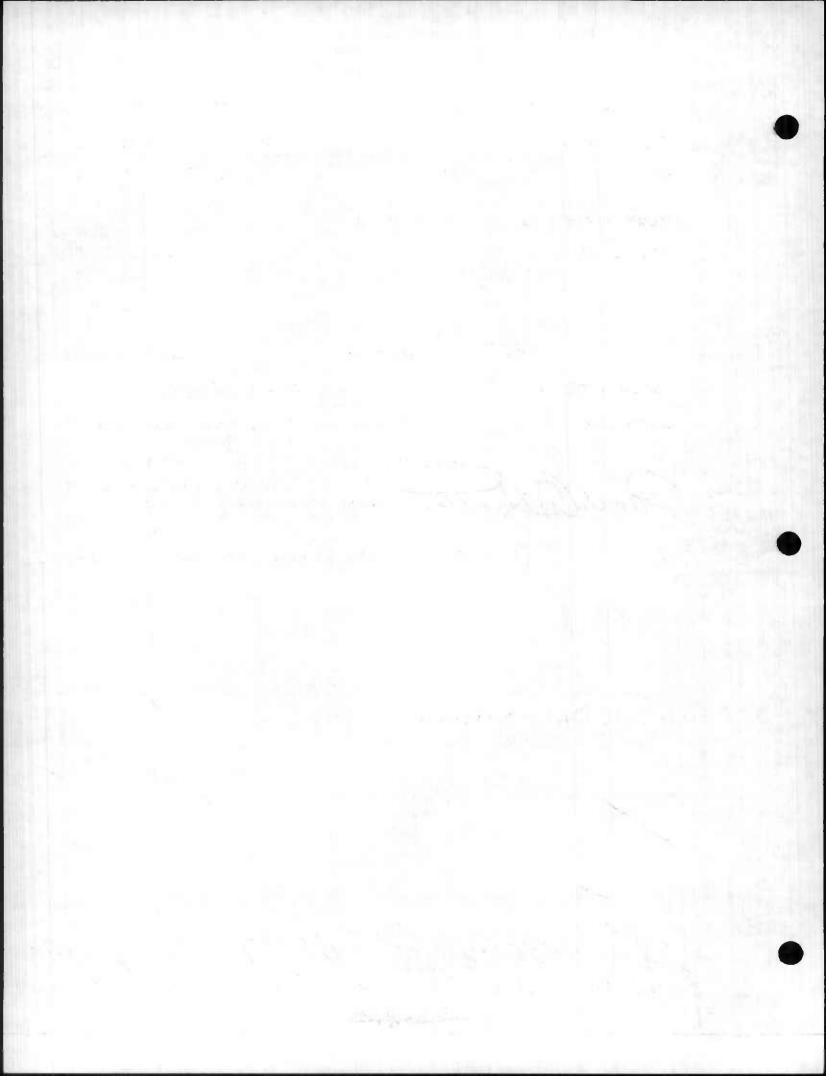
4 | Homicide

31. Dete filed (Month, Dey, Yaer)



State of Maryland / Department of Health and Mental Hygiene 8 02 1 15

					Cei	rtificate of	Death			Reg. No.	O	
		1. Decedent's Name (First, Middle, La	est)						2. Dete of Dea		Yeer	3. Time of Death
Physic /Medi		LORRAINE	RAE	HAEGERI	CH				JANUAR'	Y 10 1	998	5:10 AM
Exami		4a. Fecility Neme (If not institution, git	ve street end numb				4b. City, To	own, or Lo	cation of Death	4c. County	of Deeth	
		6 FERNDALE AVE	NUE				GLEN	BURN	IIE	ANNE	ARUN	IDEI.
Funeral		5. Social Security Number 6.	Sex 7	. Age (In yrs. lest I	birthday)	If Under 1 Year	If Under					plece (State or Foreign
Director		216-23-3053	1□M 2ĀF	70	Yrs.	Months Deys	Hours	Min.	8. Date of Birt (Month, De) 11-11-2	v, Yeer)	MARY	I.AND
		Usuel Residence of Decedent										
/lan		10a. State 10b. County		10c. City, To	wn or Lo	ocation					1	10d. Inside City Limits
Man	to	MARYLAND OUEEN A	NNES	STE	VENS	VILLE						1 ☐ Yes 2 No
r 28a-f show	9	10e. Street end Number				10f. Zip Code				10g. Citizen of	Whet Cou	ntry?
with a or	0	111 OAK STREET				216	66			U.S.		
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items inerms	5	1 Never Married 2 Married	Armed Force	:00?	10.	Was Decedent of If Yes, specify Cul	oan, Mexica	n, Puerto I	Rican, etc.)	Bie	ck, White,	
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Pa ant: ury		4 ☐ Donetion 5 ☐ Other (Speci	fy)	CHESA	PEAK	E CREMAT	ORY,	INC. 1	998]	BELTSVI	LLE,	MD
permit. Pages 1 end Department of Health important: if Item 27 any injury or other to		21. Signature of Funeral Service Lice	rison (22	2. Name end Addr	ess of Fecil	STNC	יו ביירטאו	FUNERAL	HOME	Z DA
20 5 5 8		(Stone lell	. IX	//	<i>)</i>	SECOND	AVENII					*
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or effe	Certification:	4 ☐ HomicIde	building	, etc. (Specify)					City or Tov	vn, Stete)		
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	a C	29a, Certifier 12 Certifying Pl	hysician: To the b	est of my knowled	ge, deet!	occurred at the t	ime, date er	nd plece. 6	nd due to the	ceuse(s) and m	enner es	steted.
Fur etely	edicai	(Check only 2 Medicat Example)	miner: On the bas end menne	is of examination e	end/or in	vestigation, In my	opinion, de	eth occurre	ed et the time,	dete end plece,	end due t	o the cause(s)
To the To the comple	Me	29b. Signature and little of certifier				29c. Licer	se nu <i>m</i> ber			29d. Date signe	ed (Month,	Dey, Year)
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		(Jusell	(100	1 Cll	NT.	V.	111	17		J9n4	914	12,1118
		36. Name and eddress of person who	completed cause	of deeth (Item 23e) (Type,	Print)		11		^	-	1 - 1
	0	(MISELIVE DELIC	4/10-16	007: (1	ain	HIGHWay	1 , 341	1060	2,01	en lund	118,	1206/
Sta	ate	31. Date filed (Month, Day, Year)		gistrar's Signature		/			,			
Regist	rar	JAN 16	1998	Juna David	1-1-1	andelle						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No." 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** . Month Year Clara Frances Bowles Danuary 13 1998 Location of Deeth 4c. County of Deeth Hartsoe :40 A.N /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Fallston Harford Fallston General Hospital 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer)
July 11, 1919
9. Birthplece (State or Foreign County)
North Carolina 7. Age (In yrs. lest birthday) **Funeral** 1□M 2√F Deys 214-12-9251 78 Yrs. Director Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow edical Examiner must be notified at Director 1 ☐ Yes 3 No Maryland Harford Bel Air 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2122 Ruffs Mill Road 21015 USA Funeral 11. Maritel Status 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 X No Specify: White Completed by Specify: 3 ☑ Widowed 4 □ Divorced traumatic event, the Medical 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry dartsue nd Mental Hygiene. marked other than Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be 90 end Mental Clarence Howard Bowles Roxie (NMN) Carroll Pages 1 end 2 should I sent of Health end Meni 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) If itam 27 or other tr Ronald R. Hartsoe/Son 2107 Allibone Road, Bel Air, MD 21015 Baltimore, 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 12 Buriel 12 Cremetion 3 DRemoval from State Department of Important: If any injury or Bel Air Memorial Gardens 1/17/98 Bel Air, MD 4 Donetion 5 Othe 22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 50 West Broadway Street, Bel Air, MD not enter the mode of dylng, such as cardiac or respiratory errest, Approximete intervel Between Onset end Deeth Physician /Medical Immediete Ceuse (Finel nenmania diseese or condition resulting in deeth) Examiner Due to (or es e consequenca of): Physician/Medical Examiner is certificate has been signed by the attending physicien and director, page 2 should be detached for use es the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Be Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Imonaly disease After this certificate has 20 No 1 Tyes 1 ☐ Yes 2 No or Attanding Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA To the Hospital or Attanding Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral! 27. Menner of Death Date of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation Veturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Medicai 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and due to the cause(s) end menner steted. 29e. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 435522

impleted cause of death (Item 23e) (Type, Print)

32. Registrer's Signeture Randall

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Bel Air Maryland

State

Registrar

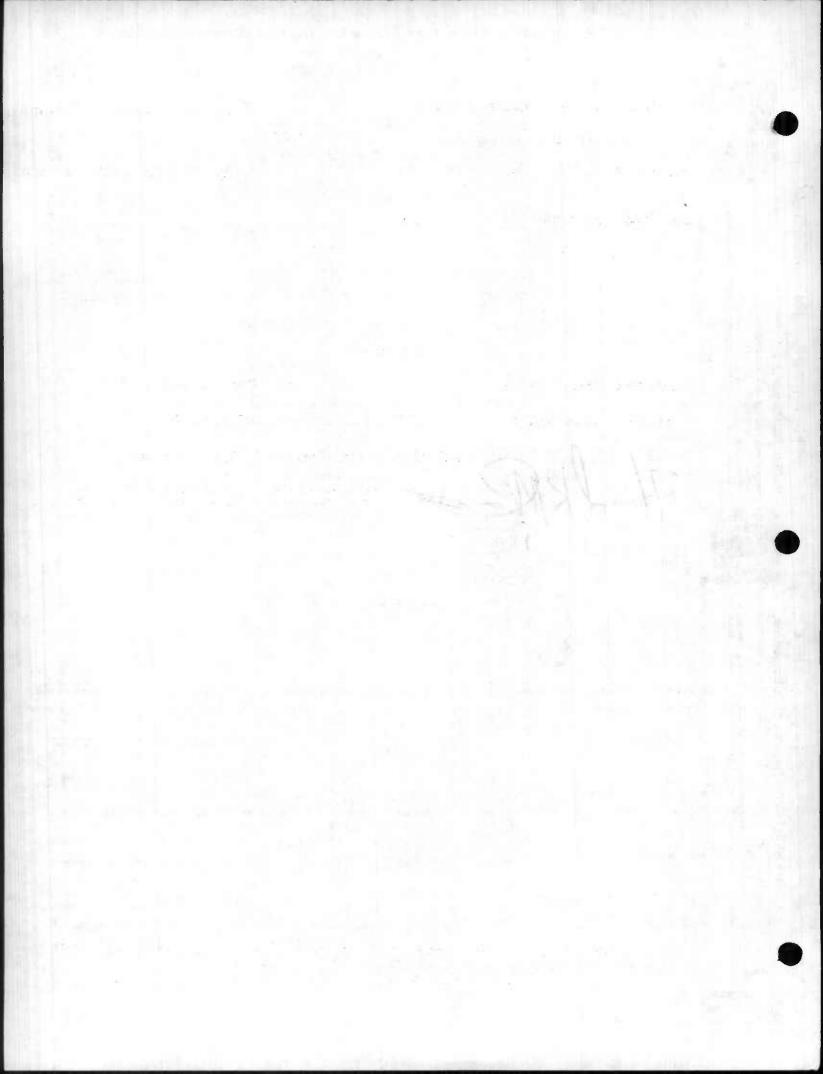
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30. Neme and eddress of person who co

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31. Dete filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Date of Deeth Month Lola 11:35 a.m. Jean Hull January 11, 1998 4e. Fecility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deeth Harford Memorial Hospital Havre de Grace Harford 5. Sociel Sacurity Number 7. Aga (In yrs. lest birthday) Birthplace (Stete or Foreign Country) 1 M 2 KF 212-50-4311 47 Yrs. Usuel Residence of Decadent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Maryland Harford Havre de Grace 10e. Street end Numbar 10g. Citizen of Whet Country? 515 Warren Street Apt. #13 21078 U.S.A. 12. Was Decadent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Give Yaer or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Navar Married 2 Married Specify: White 1 ☐ Yas 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker In home 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) James Weaver Matilda Spies 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robert Lee Hull (Husband) 114 Darlington Road, Havre de Grace, MD 21078 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. 1/12/98 West Chester, PA 21. Signatura of Funerei Sarvice Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 23e. Pert1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Aberdeen, Maryland 21001-3399 Approximete Intervel Between Onset end Death End stage multiple sclerosis Immediete Ceusa (Final diseese or condition resulting in deeth) Sequantially list conditions, if eny, leading to Immadiate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Dua to (or es e consequance of): Pour nutrition Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to complation of cause of deeth? 24a. Wes an eutopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

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items 23a

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permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiena. Important: if item 27 is marked other than "na any injury or other traumatic event, the Mede.

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Box 68760. P.O. Division of Vital Records, certificata Hospital or Attending Physician: this After death. Director: / within 24 hours a To the Funeral I. complately filled

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25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending 1 Neturel 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicida 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 1 Cartifying Phyaician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examinar: On the basis of exeminetion and/or investigetion, in my opinion, deeth occurred et the time, dete and piece, end due to the cause(s) end menner stated. 29a. Certifier (Check only

29b. Signature and title of certifie 29c. Licensa number 29d. Date signed (Month, Day, Year)

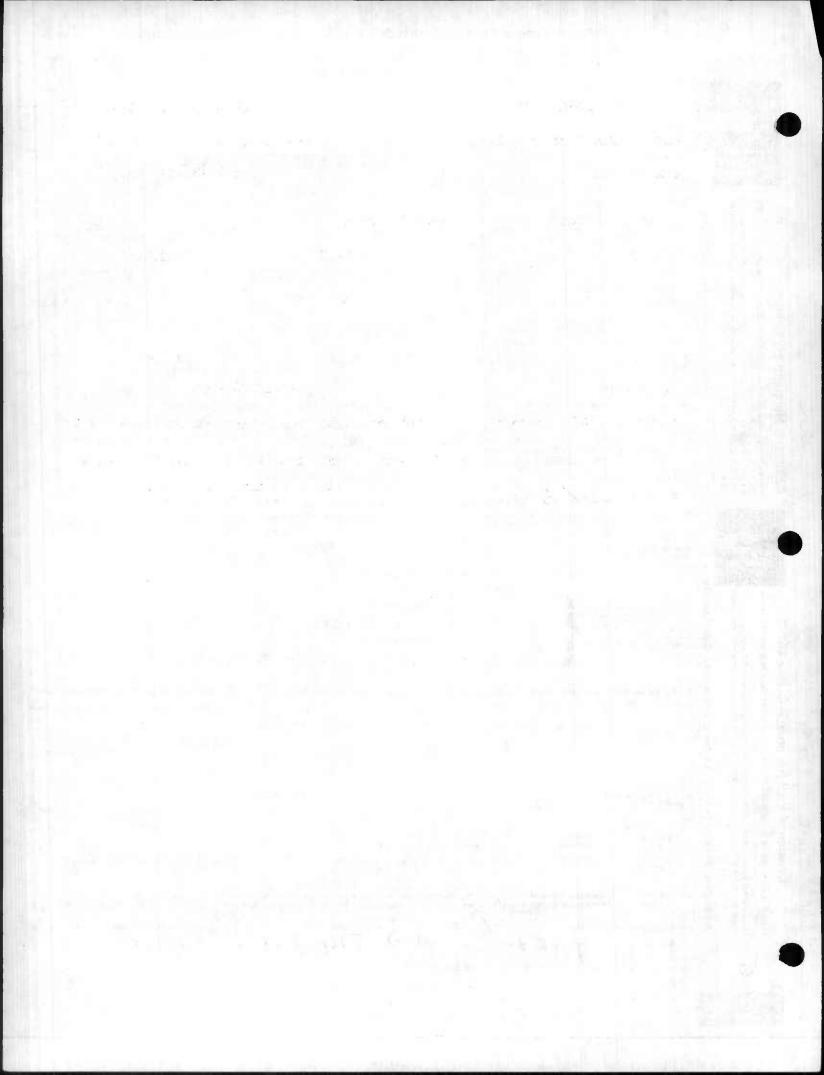
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

5 UNION AVE, HAVRE de GRACE MD 21078 KooLi 31. Data filed (Month, Dey, Year)

State Registrar

32. Registra's Signeture.

8 > Jahn Sauchen Randall 1 3 1998 ▶



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8 Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Dete of Death 3. Tima of Death Month Yaa Z:35 pm Ephraim JOSEPH 98 10 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 5. Sociel Security Number If Under 1 Year | If Undar 24 Hrs. 6. Sax 7. Age (In yrs. lest birthday) Birthplaca (Stata or Foreign Country) 1√2 M 2□ F Days Yrs. 577-08-1859 1902 ST. LUCIA 95 Usual Rasidence of Dacedani 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 □ No MARYLAND ANNE ARUNDEL SHADY SIDE 10e. Street and Number 10f. Zip Coda 10g, Citizen of What Country? 1725 COLUMBIA BEACH ROAD 20764 US Wes Decedant Evar In U,S. Armed Forcas? 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Americen Indien, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Give Yaer or Datas: 1 ☐ Navar Married 2 ☐ Married 1 Yas 2√ No Specify: BLACK Specify: 3XWidowed 4 □ Divorced 15. Decedant's Education (Specify only highast grade completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry Elemantery/Secondery (0-12) College (1-4or 5+) MAINTENANCE PRIVATE INDUSTRIES 17 Fethar's Nama (First Middle Last) 18. Mothar's Name (First, Middla, Maidan Sumema) UNOBTAINABLE MARIA BENJAMIN 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Steta, Zip Coda) MAURICE JOSEPH (SON) 11301 PEACOCK HILL WAY GREAT FALLS, VA. 22066 20b. Place of Disposition (Nama of cematary, cramatory or other plece) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1 Surial 2 Cramation 3 Ramoval from State ANNAPOLIS MEM. GARDENS 1/17/98 ANNAPOLIS, MD. 4 □ Donetion 5 □ Other (Spacify) 21. Signature of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility WM. REESE & SONS MORTUARY, P.A. ees 23a. Part1. Entar tha disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batwaan Onsat and Death Immediata Causa (Finel oneumania disaasa or condition resulting In daath) Dua to (or as a consequence of) Failure Dua to (or es e consequance of): Dua to (or as e consequence of) 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown 24a. Was an eutopsy performed? 24b. Ware autopsy findings available prior to completion of ceusa of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Place of Death (Chack only ona) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA

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Hospital or Attending Pi 124 hours after death.
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To the Hospital c within 24 hours af To the Funeral D completaly filled?

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Certification:

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Box 68760.

Division of Vital Records. P.O.

Physician

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7 is marked other than "natural", or items 23a or 28a-f ahow traumatic avent, the Medical Examiner must be notified at

permit. Pegas 1 and 2 should be filed within 72 hours after a Dapartmant of Haalth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite; any injury or other traumatic avent, the Madical Examina

Baltimore, Maryland 21215-0020

with the Maryland

daath

Sequantially list conditions, if any, laading to immediata causa. Enter Undarlying Causa (Disaase or injury that initieted avants rasulting in daath) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

25. Wes case rafarred to medical axaminar? 1 ☐ Yas 2 ☐ No 27. Manner of Daath

5 Panding invastigation

6 Could not be determined

28a. Data of Injury (Month, Day Year)

28c. Injury at Work? 28b. Tima of 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier

1 Naturel

2 Accidant

4 Homicida

3 ☐ Suicida

1 🗹 Certifying Phyaician: To tha best of my knowledge, daeth occurred at tha time, date end place, and due to the ceuse(s) end mennar as stated. 2 Medical Examinar: On the besis of axamination and/or invastigetion, in my opinion, death occurred at the time, date and place, end due to the causa(s) and manner stated.

29b. Signetura and titla of certifier

29c. Licensa number

1898 Januar 10.

29d. Data signed (Month, Day, Year)

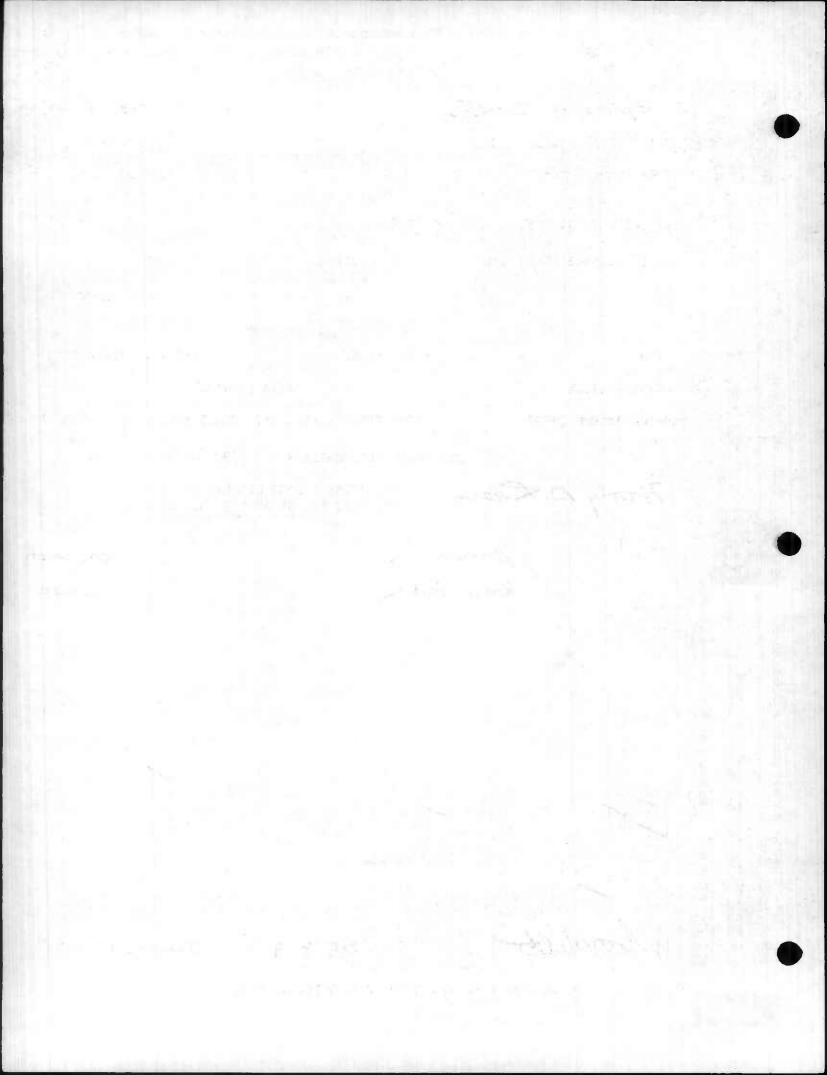
30. Nama end address of person who completed causa of death (Item 23a) (Type, Print)

MATTHEW MOLTER 1833 31. Data filad (Month, Dey, Veer) JAN 1 3 1998

A FOREST DRIVE ANNAPOLIS, MD. 21401 32. Registrer's Signetura his Davidson

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify)

State Registrar

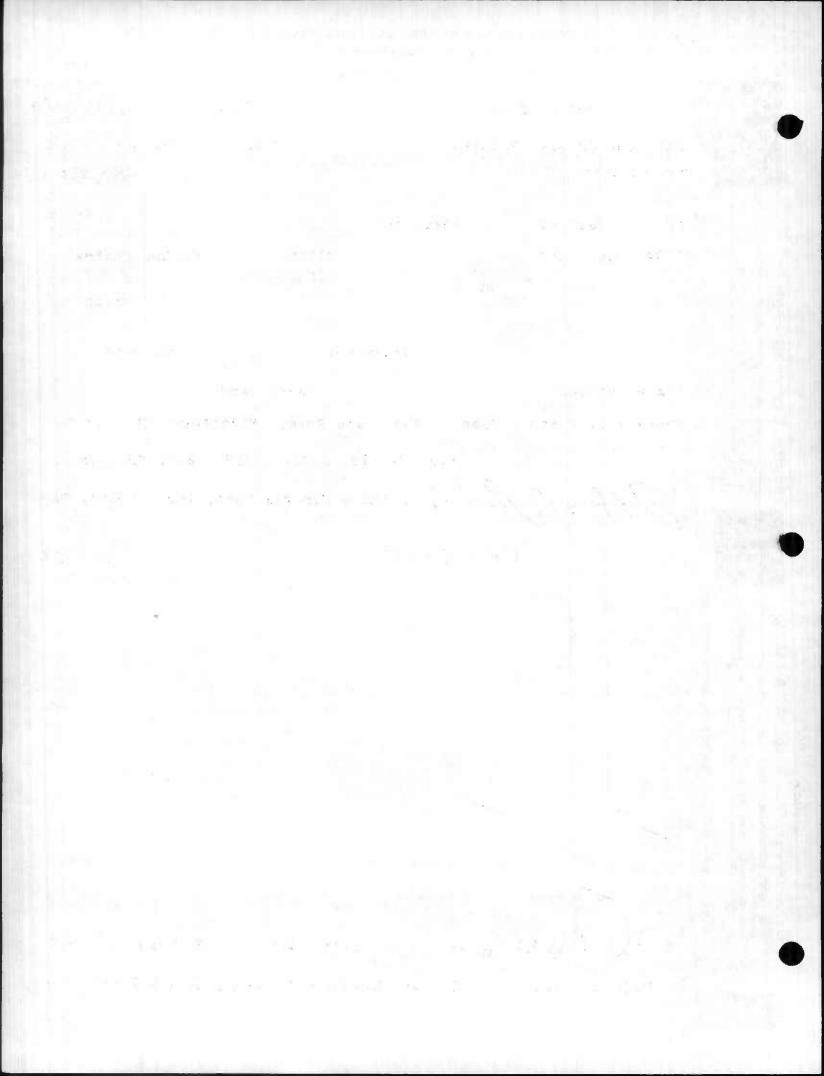


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7	or 28e-f	Funeral Director	MD Prin 10e. Street and Number	ce George's	F	orest	ville 10f. Zip Code			10g. Citizen of Wh	1 🖾 Yes 2 🗆 No nat Country?
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17/	urs efter dea al', or Items	by	11. Marital Status **Never Merried 2 M. 3 Widowed 4 Divorce	If Yes Give	es? XNo	J,S. 13	If Yes, specify Co	f Hispanic Origin? (Spuban, Mexicen, Puerto Specify:	pecify Yes or No Pican, etc.)		- Americen Indien, White, etc.
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Jo H NSON Baltimore, Maryland	Peges nent of nnt: If Ii		20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		ate	cemetery, cr	position (Name of ematory or other p rles Cem		anuary 4, 1998		uis, MO
Balt	permit. Depertrimports any inje		21. Signature of Funeral Service	e Licensee #M00	690 ~~		22. Name end Add				neral Home is, MO 63115
Box 68760,	Physician perfecte pe executed (Medical Examine ettending physician end lor use es the burial-transit	n/Medical Examiner	23a. Parti. Enter the disease, shock, or heart failure. Li Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	e. ————————————————————————————————————	Due to (c	or as a consider of the consideration o	equence of):	failur Tra vos		Congel	Approximate interval Between Onset and Death
	thet the deeth ed by the etter deteched for	Physician/M	Part II. Other elgnificant condi	tions contributing to deat	th but not res	sulting in the	underlying ceuse	given In Pert I.			ribute to the cause of death?
Division of Vital Records, P.O	e law requires hes been sign ge 2 should be	Completed by	/	<i>O</i>					perfe	ormed?	24b. Were autopsy findings available prior to completion of cause of death?
Ital		Be Co	25. Was case referred to medic	cal				26. Plece of Deat	th (Check only	10	1 ☐ Yes 2 ☐ No
sion of V	ng Phys fter this ineral di	Certification: To E	(= =) tooldont	stigation		ER/Outpation 28b. Time Injury	of 28c. In			dence 8 Other	
Divi	tal or Att	Certifi	3 Suicide 6 Couldete	mined 200. Place of	Injury - At he , etc. (Specif	ome, farm, s fy)	treet, factory, offic	8	28f. Location (City or To	Street and Number wn, State)	or Rural Route Number,
	To the Hospital or Attendity within 24 hours effer deeth. To the Funeral Director: A completely filled in by the form	edicai	29a. Certifier (Check only one) Certify	ring Phyalcian: To the be al Examiner: On the basi end manner	s of examine	wledge, dea ation end/or l	ith occurred at the investigation, in my	time, dete and place, opinion, deeth occur	and due to tha red at the time,	cause(s) and mann date and place, en	er as steted. d due to the cause(s)
•	To t with To t	M	29b. Signature end title of certif	en n	· D .	- 00:1/-		1296	2	29d. Date signed (Month, Day, Year)
	Sta	ite	30. Name and address of person 2000 DA 31. Date filed (Month, Day, Yea JAN 1	LEE-L	inter's Signa	T 23a) (Type	79096	IL BRI	queh	Ave.,	offint on mo
	Registr	ar	JAN 1	6 1998	wie bu	ridow-7	andille				

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			1 Decederals Name (First Middle)				ertificate of	Death		Reg. No.	02	. 120
144	Physici	ian	1. Decedent's Nama (First, Middle, L						2. Deta of Da Month	Dey	Yaar	3. Tima of Death
	/Medi	cal		C. JONES				4b. City, Town, or Lo	DANUA	-	1110	2.38 PM
	Examir	ner	4e. Facility Nama (If not institution, g							,		
	Funeral		Fallston Gene 5. Social Security Number 6.	ral Hosp	ital ge (In yrs. la	ast birthday	if Undar 1 Year	Falls If Undar 24 Hrs.	ton 8. Date of Bir	Harf	9 Rinthole	ca (Stata or Foraign
	Funeral Director		219-16-4013 Usual Residence of Decedant	1□M 2K0F	74	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da	ay, Year)	West	Virgini
	the Maryland 28a-f show)r	10a. State 10b. County			, Town or I					100	d. Insida City Limits 1 ☐ Yes 2 No
	28a-f	Director	MD Harfo 10e. Street and Number	rd	Wh:	itef				40- 02	450	11-10-
	with with	ā	1304 Heaps Ro	2 4			10f. Zip Coda	1160		10g. Citizen of \		
	leath	Funeral	11. Marital Status	12. Was Decedent	t Ever In U.S	S. 13		21160 dispanic Origin? (Sp	ecify Yas or No	United	e - Amaricer	
020	permit. Peges 1 and 2 should be filled within 72 hours efter death with the Maryland Department of Heelth and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Event her mist be notified a once.		1 Naver Merried 2 Marriad 3 Widowad 4 Divorced	Armed Forcas 1 Tyes 2 1 If Yas, Giva Yaar or Datas:	? No		If Yas, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Spean, Maxican, Puerto Specify:	Rican, atc.)		ck, Whita, etc	c.
altimore, Maryland 21215-0020	72 hou	Be Completed by	15. Dacadant's (Spacify only highast g	Educetion		16e. Dac	edant's Usual Occup	pation during most of work d)	ina	16b. Kind of Bi		
121	ne. han r	mple	Elementary/Secondary (0-12)	Collage (1-4or	5+)				my	0	***	
D 0	Hygie ther t	ပိ	17. Father's Name (First, Middla, Las	et)		H	omemaker	18. Mothar's Nam	a (First Middle		Home	
an	entel ced o	To Be	Aaron Seymour	•				Laura		, maidan Suman	16)	
ary	shound M	F	19a. Informant's Name/Ralationship			19b. Mai	ling Addrass (Street	and Number or Run		er, City or Town,	Stata, Zip C	coda)
Σ	elth e		Russell T. Jo	nes / Hu	sb.	130	4 Heaps	Road,	Whitef	ord, M	D 2	21160
ore	of He of He litern		20a. Mathod of Disposition		20b. Pla	ace of Disp	oosition (Nama of amatory or other pla	ca)	Data	20c. Location -	City or Town	n, Stata
ii.	Peg ment ant: M		1 Burial 2 Cremation 3 4 Donation 5 Other (Space		4		erris,		/15	West (Chest	er, PA
Balt	Departit. Departimport		21. Signatura of Funaral Service Lice	ensee	0.	1	22. Nama end Addra		Homo	Too	Doll	- D3
	_		23a Paul. Enter the disease, of confidence, or heart failura. List only	mplications that cause	d the daath.	4		Funeral ng, such es cardiac			A	pproximate
	Physician		phoce, or heart failura. List onl	y one ausa on aach i	line.						lr C	ntarval Betwaan Onset and Death
	/Medical Examiner		Immediate Ceusa (Final disaase or condition	· UR	OSE	PS	IS				01	NE DAY
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	uted Insit	Examiner		b			· · ·				<u> </u>	
oʻ	ficete be executed physician end is the buriel-transit		Sequentially list conditions, if any, laading to immadiata ceusa. Enter Undartying Cause (Disaase or injury		Dua to (or	es a conse	aquance of):				1	
68760,	ate be hysicia	edical	Cause (Disaase or injury that Initiated avants rasulting in death) Last	C	Dua to (or	as a conse	equence of);				-	
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Вох	eath certifether ettending	Physician/M									1	
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υ. Ω.	s thet	by P							''	Tes 2LING	3 Proba	DIY 4 1 ONKNOWN
AdA Joved Division of Vital Records, P.O.	The law requires that the death certi ate hes been signed by the ettending page 2 should be deteched for use e	ted t							24a. Wes	an autopsy	24b. Wara	a autopsy findings ebla prior to
200	law re es be	Completed										pletion of cause
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u C	tending Physeeth. or: After this the funeral	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Panding	28a. Data of Inju (Month, Da	ay Year)	28b. Tima Injury	Wo	ryat rk? Yas 2 □ No	28d. Dascribe	how injury occur	red	
isi	Attending ir deeth. ector: After by the fune	ficat	2 Accidant Invastigati 3 Suicida 6 Could not detarmina	be on Diese of te	iury - At hor	na. farm. s	traat, factory, office		28f. Location (Straat and Numb	er or Rural F	Routa Number.
S	s effer i Dire	Certification:	4 ☐ Homicida detarmina	building, e	tc. (Specify))	,		City or To	wn, Stata)		
	To the Hospital or Attenwithin 24 hours efter deal within 24 hours efter deal To the Funeral Director: completely filled in by the	Medical C	29a. Certifiar (Check only one) Manager Printing P	hyalcian: To the best minar: On tha basis o and manner si	of axamination	rledga, daa on and/or i	th occurred at tha tir nvastigation, in my	me, data and place, opinion, death occurr	and due to the red at the tima,	cause(s) and ma data and place,	nner as state and dua to the	ed. ne cause(s)
	within 2 To the comple	Me	29b. Signature and title of certilier				29c. Licens	1 1 1 1 1		29d. Date signe	d (Month, Da	ıy, Year)
	,) den	COV W	(D .		04	16667	1	JANUAR:	1 13	1998.
	15		30. Name and address of person who	completed ceusa of	•							
			SYEDAH S.G	ILANI.Y	M.D.	40	NORTH	AVE. #	424	BELAI	RMI	21014
	Sta		31. Data filad (Month, Day, Year)	32. Ragist	rar's Signatu	ura	Parlell		•			,
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State of Maryland / Department of Health and Mental Hygiene Q

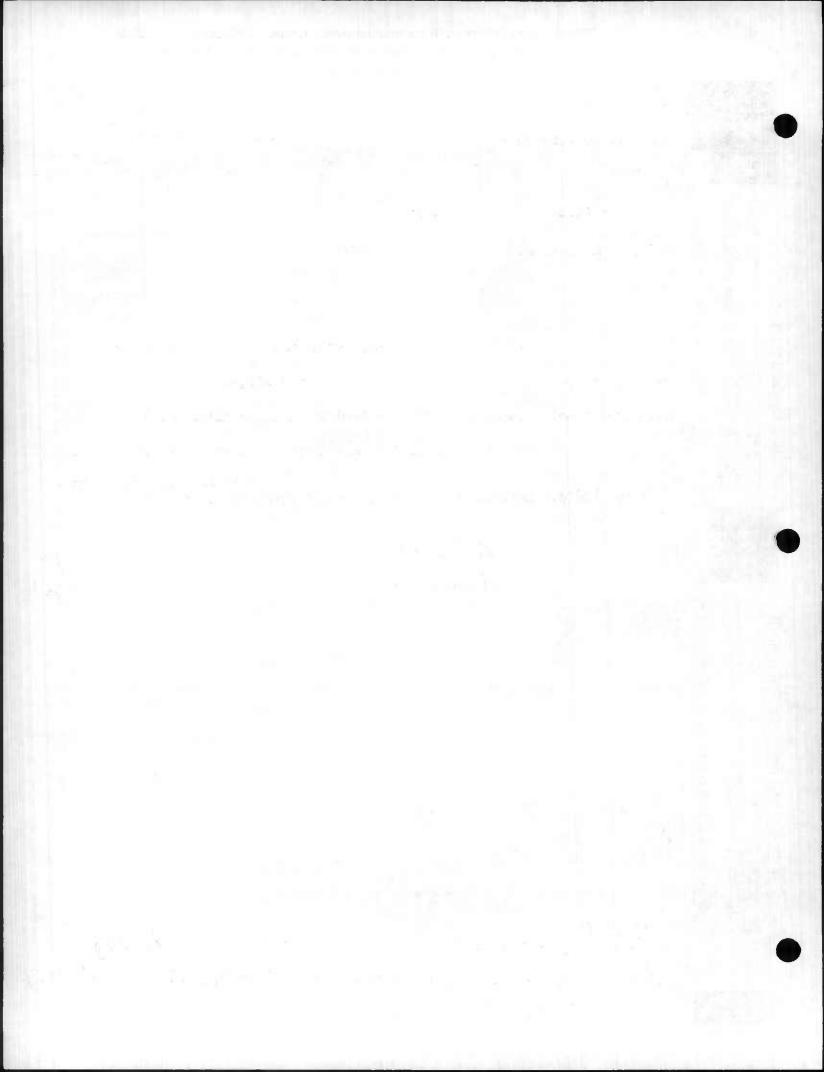
		AMEND: #22 1/16/9 1. Decedent's Name (First, Middle, Last		Heal(eartifies	te of	Death	2. Date of De	Reg. No.		Total *
Physic	ian	KERN LE						Month	Day	Yeer	Time of Death
/Med		4e. Facility Name (If not institution, give					th City Town o	JAN r Location of Deat	6 199		5:55 PM
Exami	ner	NATIONAL NAVA		NTER			BETH			NTGOMER	RY
Funeral Director		5. Social Security Number 6. Se 306-50-9027			Month	ler 1 Year s Days	If Under 24 Hi Hours Mi	s. 8. Dete of Bir	h y, Year)	9. Birthplace Country)	(State or Foreign
yland		Usuel Residence of Decedent 10a. State 10b. County	10c. C	ity, Town	or Location					10d. I	nside City Llmits
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ath with the 23a or 2	rai Dire	10e. Street and Number 21756 Carriage Dri				2ip Code 4661			of Am	States erica	
5-0020 72 hours after death with the Maryland natural; or items 23s or 28s-f show deal Exercities frout to notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☐ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1X1 Yes 2 □ No If Yes, Give Nov Yeer or Dates June			edent of Foecify Cuba 2 No	lispanic Origin? (an, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)		ee-American Ir ck, White, etc. White	
2 2	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. D		vork done use retired	during most of w	driking		usiness/Industr	
id 212 filed with Hygiena, wher ther		17 Esthada Nama /First Middle Loct)	2	Qu	ality	Cont				acturin	g
E data	Be C	17. Fether's Name (First, Middle, Last) Walter Lee Korkhou	ISA				Mary Lo	ame (First, Middle,	Majden Sumam	10)	
Marylan d2 should be ith and Mental it? Is marked of traumatic eve	2	19a. Informent's Name/Reletionship (7)		196 A	Mailing Addre	es (Street		Rural Route Number	er City or Town	State Zin Cod	(0)
Magnet and 2 lith an lith an 127 lis		Beverly Korkhouse/						South B			
E - 1 5 6		20e. Method of Disposition N Burlal 2 □ Cremation 3 □ F 4 □ Donetion 5 □ Other (Specify)	Removal from State	Plece of D cemetery,	isposition (A cremetory of awn Ce	leme of r other plac	ce)	January 10, 1998	20c. Location - South	City or Town,	
Baltimol permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Licens			22. Name Saint	and Addre	ss of Facility	Saint Jos ral Home ver Road,	eph Fun	eral Ho	
Physician /Medicai Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only of the disease or condition resulting in death)	lications that caused the dea ne cause on each line.					ac or respiratory a	rest,	Inte	oroximate rval Between set and Death
death certificate be executed eathording physician and eathording physician and	/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	b. — Due to (or as a co	nsequence o	r):					
BOX eath cert attending	ciar	D-14 04 1 14 1								1	
that the ed by the detache	y Physician/	Pert II. Other aignificant conditions con	itributing to death but not res	sulting in ti	he underlying	cause giv	en in Part I.	23b. Did			cause of death?
records, he law requiras the has been signe	Completed by								an autopsy med?	availabl	utopsy findings le prior to tion of cause 1?
= F # d								10	res 2 No	1 □ Yes	a 2 No
Of Vital Physician: The	Be	25. Was case referred to medical examiner?	Hospital: X			Oth	or:	eath (Check only o			
Phys r this	. To	1 Yes 2 No	lospital: 1 Inpatient 2	28b. Tim	etient 3□ I		4 LI Nursing	Home 5 ☐ Reside	dence 6 Oth		
OLVISION O lor Attending Ph after death. Director: After th J in by the funeral	ertification:	1 Auturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Plece of Injury - At h	Inju	M M		k? Yes 2 □ No		Street and Numb		ute Number,
Hospita 24 hours Funeral staly filled	edical Ce	29a. Certifier 1 ★ Certifying Physic (Check only one)	sicien: To the best of my kno ner: On the basis of examina	owledge, d	leeth occurre or investigation	d et the tin	ne, date and place pinion, death occ	ce, and due to the curred et the time,	ceuse(s) end me date end place, o	enner as stated	cause(s)
To the within 2 To the comple	Mec	29b. Signature end line of certifier	menner stated.			9c. Licens	o number 00021111		29d. Date signed	d (Month, Day,	Year)
		30. Neme and address a person who co	empleted cause of deeth (Iter	m 23a) (Tv				AVAL MED	TCAT CEN	TEP	
		MARK J. PETRIZZIE			,			D 20889-		1151	
Sta	ite	31. Date filed (Month, Day, Year)	QQQ 32. Register's Sign		Manda						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 3. Time of Deeth 2. Dete of Deeth

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical	ı	Agnes	Krieg	ger						Jan 1	0 199	Yeer 8	6:40pm
Examiner	I	4a. Fecility Neme (If not institution, giv	ve str ee t end nu	mber)				4b. City, Town, or L	ocation of Deeth	4c. County	of Deeth	
	ı	Long Vie	ew Nursin	g Home					Manches	ter	Carrol	.1	
uneral irector		5. Social Security N 220–38–86	555	Sex 1□M 2∏ F	7. Age (In	yrs. last birti	frs. If Unc	der 1 Year is Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey May 28	, Year)	9. Birthp Coun Mass	lece (Stete or Foreign try) achusetts
fled at		Usuel Residenca o 10e. Stete Md.	f Decedent 10b. County Carroll			City, Town	or Location					1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
r items 23s or 28s-f el inter must be notified Funeral Director	-	10e. Street end Nu 4101 Old	mber 1 Nationa	ıl Pike				Zip Code			Og. Citizen of V		try?
important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		11. Maritat Status 1 ☑ Never Marr 3 ☐ Widowed	ied 2 Married	12. Wes Dec Armed F 1 Yes If Yes, G Yeer or D	orces? 2 No ive	In U,S.	If Yes, sp	cedent of Poecify Cubo	dispenic Origin? (Spen, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Btec	a - Americ k, White, white	etc.
it, the Vedical It.		(Spec	15. Decedent's E cify only highest gro ondary (0-12)	ade completed)	1-4or 5+)		life. DO NOT	work done use retire	during most of work	king	16b. Kind of Bu		lustry
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sician		23a. Pert1. Enter t shock, or hea	he disease, or com int failure. List only	plications that	caused the deech line.	deeth. Do n	ot enter the m		ng, such es cardiac				Approximate Intervel Between Onset end Death
edical miner	ı	Immediate Cause disease or condition resulting in death)	(rinai on	θ		to (or es e c	onsequence of	of):				- 1	10 gr
the attending physician and ned for use as the burial-transit risician/Medical Examiner	1	Sequentially list co if eny, leeding to in cause. Enter Unde Ceuse (Diseese or thet initiated events	nmediate erlying Injury	b		to (or es e c	onsequence o						10%
he attending physical for use es the siclan/Medi		resulting in deeth)	Lest	d			311004001100						
		Pert II. Other elgnif	ficant conditions of	contributing to d	eath but not	resulting In	the underlying	g cause giv	ven In Pert I.	23b. Did to		tribute to	the cause of death?
page 2 should be detact										24a. Wes e		COI	ore eutopsy findings pilable prior to repletion of cause deeth?
is certificate has director, page 2 director, page 2		25. Wes case refer	red to medicat						26. Plece of Deet	1 ☐ Y		1	Yes 2□ No
neral direc	-	examiner? 1 Ves 2 2	h	28e. Dete		2 ER/Out		DOA Oth	ry et	ome 5 Resid			')
To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To		Naturel Accident Suicide Homicide	Pending investigation Could not be determined	e 28e. Pleca		At home, fer	m, street, fact	1 🗆	Yes 2□No	28f. Location (S City or Tow	treet end Numb n, Stete)	er or Rure	I Route Number,
he Funeral pletely fille edical C		29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	niner: On the b	best of my ests of exam ner steted.	knowledge, nination and	death occurre for Investigetion	ed et the tir	me, date end place, ppinion, death occur	end due to the c red et the time, c	euse(s) end ma late end place, s	nner es st and due to	eted. the ceuse(s)
To th comp		29b. Signety end	title of certifier	felials			2	9c. Licens	5 511112		9d. Date signed	1	
		30. Neme and eddr	ess of person who	dellet	'n	688	Porle	Ro	nd he	Minu	ula,	m	1 2157
State Registrar	ľ	Date ined (MOI)	JAN 13	1998	Registrar's S	ignature	Rarball						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death 7, 1998 Catherine Virginia Koegler January 5:30 a.m. 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 748 Schofield Road Aberdeen Harford 8. Dete of Birth (Month, Day, Year)
Dec. 2, 1915 If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplece (State or Foreign Country) Maryland Months Deys Hours Yrs 219-03-4149 82 Usuel Residence of Decadent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Aberdeen 10e. Street end Number 10f. ZIp Code 10g. Citizen of Whet Country? 748 Schofield Road 21001 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Merital Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2224No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Specify: White 3℃Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker In home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) William Russell Schofield Lacey Cordelia Baldwin 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Arthur E. Schofield (Brother) 2211 Calvary Road, Bel Air, Maryland 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) Spesutia Cemetery 1/10/98 Perryman, Maryland 21. Signeture of Funerel Servica Licanses 22. Name end Address of Fecility Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line. Car Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24b. Were eutopsy findings eveilable prior to 24a. Wes en eutopsy performed? completion of cause of deeth?

Physician /Medical Examine

Physician

/Medical

Examiner

Director

Funeral

Aq

Completed

Be

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Funeral

Director

Item 27 is marked other than "naturel", or Items 23a or 28a-f ahow other treumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours aftar. Department of Health end Mental Hyglena. Important: if Item 27 is marked other than "naturel", or ite, any injury or other treumatic even.

Baltimore, Maryland 21215-0020

with the Maryland

death

Examiner Physician/Medical by Completed Be 10

physician the buriel USB signed by 2 should be peen certificate has page

sician and buriel-transit Box 68760 P.O. F Records. Division of Vital To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifica Certification: Director: in by the Medicai completely

State Registrar

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA sidence 8 Other (Specify) 27. Mayner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Naturel 1 Yes 2 No Investigation 2 ☐ Accident 8 Could not be 3 Suicide Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homleide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and menner as stated.

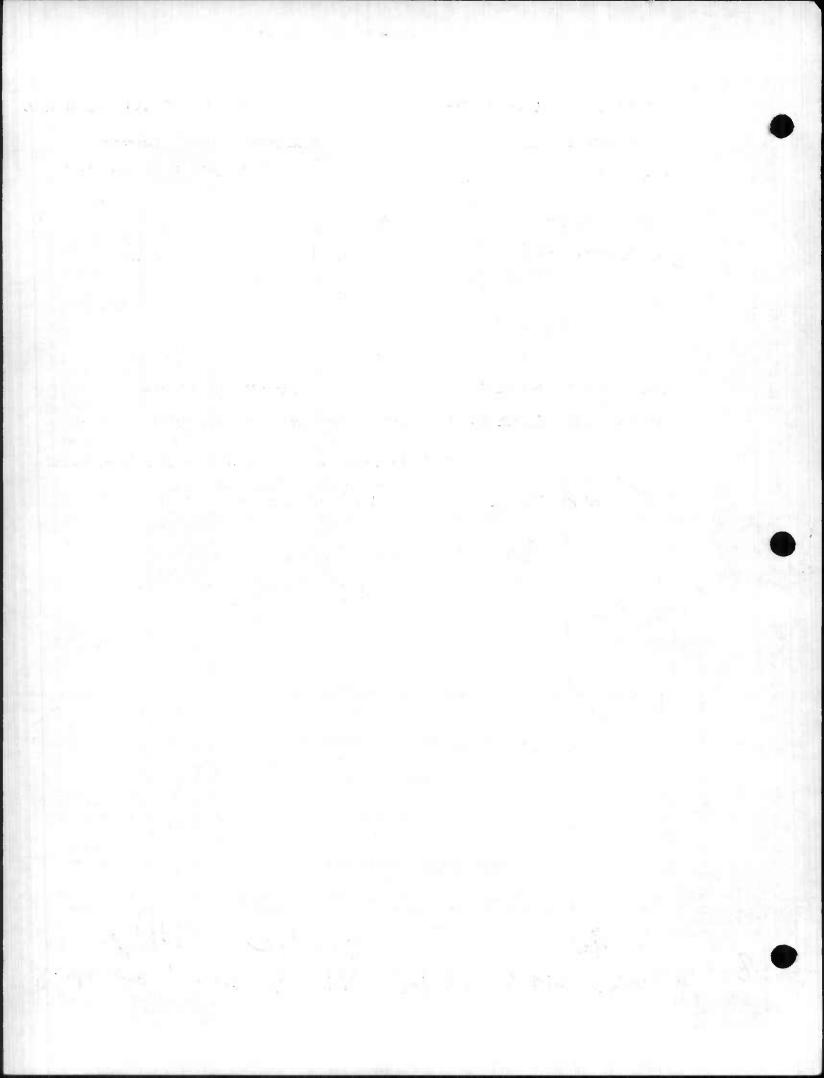
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier

29b. Signeture end title a certifie 29c. License/numbel 29d. Dete

signed (Month, Dey, Year)

erson who completed gause of deeth (Item 23a) (Type, Print) Whion

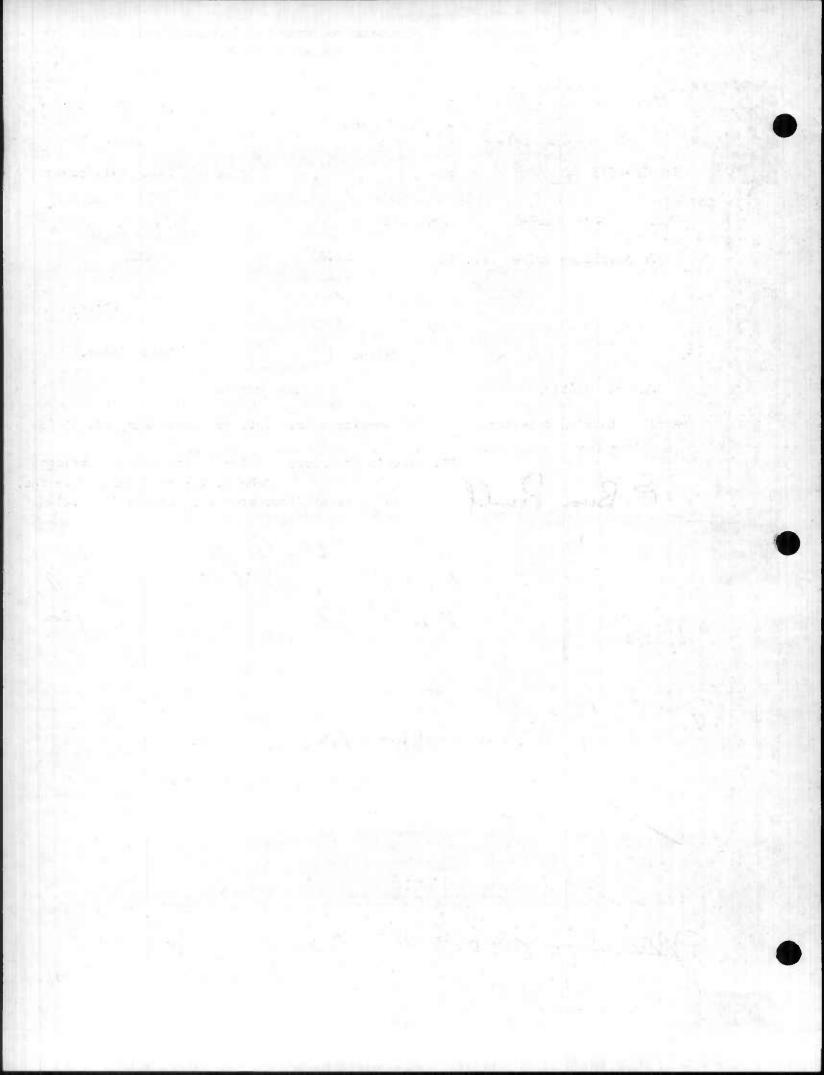
32. Registrer's Signeture . Dete filed (Month, Dey, Year) 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 8 12 2 4

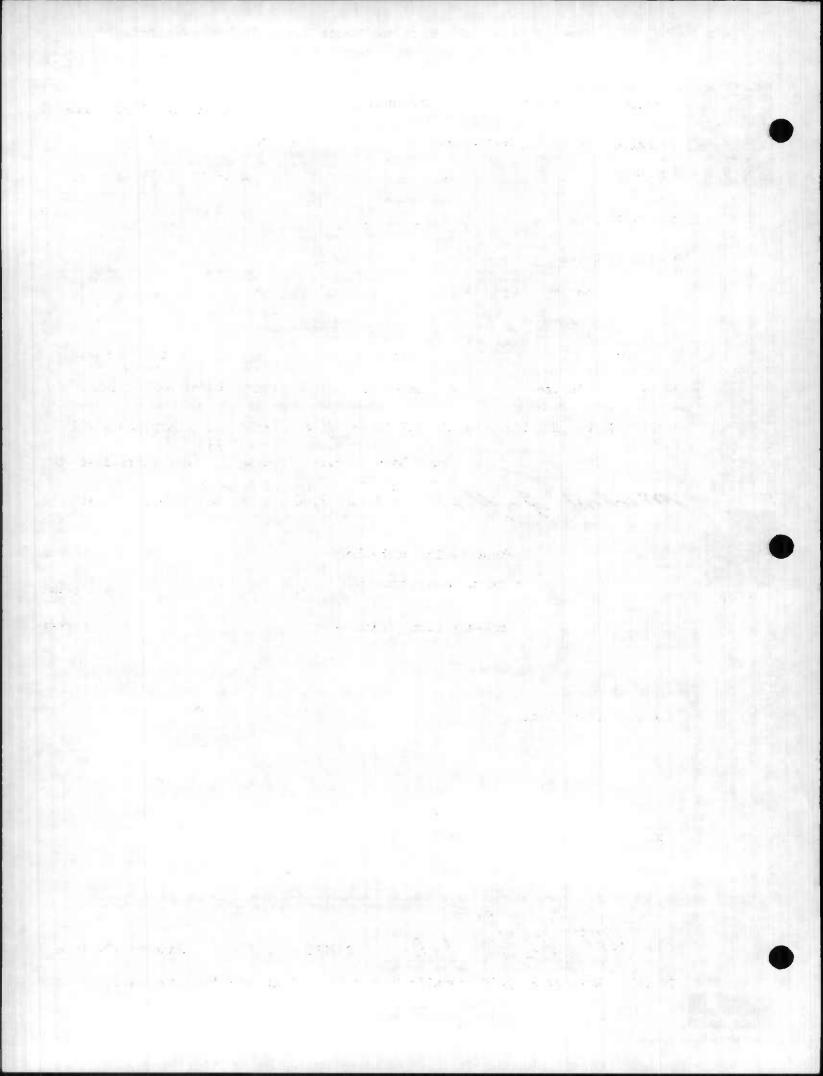
					Cen	tificate of	Death		Reg. No.	041	Y
Physicia	ın	1. Decedent's Name (First, Middle, WIFLLIE	Last)	AT	T	4 - 15 - 1		2. Dete of De Month		Year	ime of Death
/Medica Examine	or	4a. Fecility Name (If not institution, s ANNE AMN)		CTR	64 F	navicion	1b. City, Town, or	Location of Deeth	4c. County	/0	
uneral irector				ge (In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Deys	If Under 24 Hr. Hours Mir	s. 8. Date of Birt	h v Year)	9. Birthplece (S Country) Califo:	
MO W	-	10e. Stete 10b. County		10c. City, Tov	vn or Loc	ation				10d. Ins	Ide City Limit
100	io	Md. Anne A	cundel	Anna	poli	s				1 🗆	Yes 2∏N
or An	Director	10e. Street end Number				10f. Zip Code			10g. Citizen of V	Vhet Country?	
238	ra l	700 Americana	Drive Apt	. 56		2140)3		US	SA	
	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorcad	12. Wes Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Detes:			as Decedent of H Yes, specity Cube	ispanic Origin? (en, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		e - American indi ck, White, etc.	en,
natur	Completed	15. Decedent's (Specify only highest)	Education	166	Dacede	nt's Usual Occup	etion	and the en	16b. Kind of Bu	usiness/industry	-
Mag.	n p	Elamantary/Secondary (0-12)	Collage (1-4or	5+)		ind of work done of O NOT use retired	d) most or we	orking			
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0 pe	Be	17. Fether's Neme (First, Middle, La						eme (First, Middle,	Meiden Sumem	Θ)	
metic	٩	Edward Reil: 19a. Informent's Name/Ralationship	-	10	h Mailine	Address /Street		Harbin Rural Route Numbe	City as Taura	Chair Tin Contain	
trau		Marilyn Lott /									01/02
t: if item 27 is marked other than y or other traumatic event, the M		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3	Removel from State	20b. Plece o	of Disposi ory, creme	mericana tion (Neme of atory or other plea	e)	Dete	20c. Location -	S, Md.	ete
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any ir		P.C. Burn	Powel	P	14	7 Duke o	f Glouce	ohn M. Ta ester St	Annap	olis,Md	. 21401
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octor.	20	25. Was case referred to medical examiner?					26. Place of De	eth (Check only o			
S G	0	1 Yas 2 No	Hospitel: 1 Impatie			3□ DOA Othe	4 Li Nursing	Home 5 Resid			
the funeral	ation	27. Menner of Death 1 Natural 5 Pending 2 Accident investigati		y Year) 28b.	Time of Injury	28c. Injun Work M 1	ret ⟨? Yes 2 □ No	28d. Describe h	ow injury occurr	be	
in by	Certification:	3 Suicide 6 Could not determine	28e. Place of Inj building, et	ury - At home, fe c. (Specify)	erm, strae	ot, fectory, offica		28f. Location (S City or Tow	Straet end Numb in, Stete)	er or Rurel Route	Number,
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Ponietra	_	JAN 1 2 199	3 distant	wil . X	1 1 0						



State of Maryland / Department of Health and Mental Hygiene

				rtificate o			Reg. No.	02120
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/Medical			MOOOL	DIN, J	4b. City, Town, or	Januar		
Examiner	4a Facility Nama (If not institution, give							
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Funeral Director		ÑM o∏E	8 Yrs.	Months Day	s Hours Min		3, 1939	9. Birthplaca (Stata or Foreign Country) Maryland
dend w	10a. Stata 10b. County	100	. City, Town or L	ocation				10d. Insida City Limits
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offer deeth with the Mainter deeth with the Mainter a 23a or 28a-1 a linet must be notified.	10e. Street and Number		1,	10f. Zip Code)		10g. Citizan of V	Vhat Country?
th with	420 Irene Drive			2106	1		U.S.	Α.
ems rdee	11. Maritai Status	12. Was Dacedant Evar Armed Forcas?	in U,S. 13.	Was Decedent o	f Hispanic Origin? (Suban, Maxican, Puar	Specify Yas or No to Rican, atc.)		a - Amarican Indian, k, Whita, atc.
permit. Peges 1 and 2 should be filed within 72 hours effer deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. To Be Completed by Funeral Director To Be Completed by Funeral Director	1 ☐ Navar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas:		1□ Yas 2∑			Specify	
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permit. Peges 1 er Department of Hea mportant: if item in injury or other any injury or other	Burial 2 Cramation 3			matory or other p		1/14/98		
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permit. Departn Imports any inft	21. Signatura of Furiarian Sarvica Eleani.	/ //	S	ingleton	Funeral			
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he Hospii in 24 hour he Funer pletely fill	(Check only 2 Medical Exam	sician: To the best of my iner: On the basis of axar						
To the Hospital or Attending Physician: The law within 24 hours efter deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Comp	000	end mepher steted.						
C T W	29b. Signature and till 4/of contiller	011	Un		ensa number			d (Month, Day, Year)
	yuu	1	111	D42	083		January	7 10, 1998
	DR Gunta Wheeler	MD 9000 Fra			ive Relet	more Me-	valend 21	1237
	31. Data filed (Month, Day, Yaar)	32. Registrar's S		quare Dr	rve Daltl	more Mai	y Lanu Zi	LZJI
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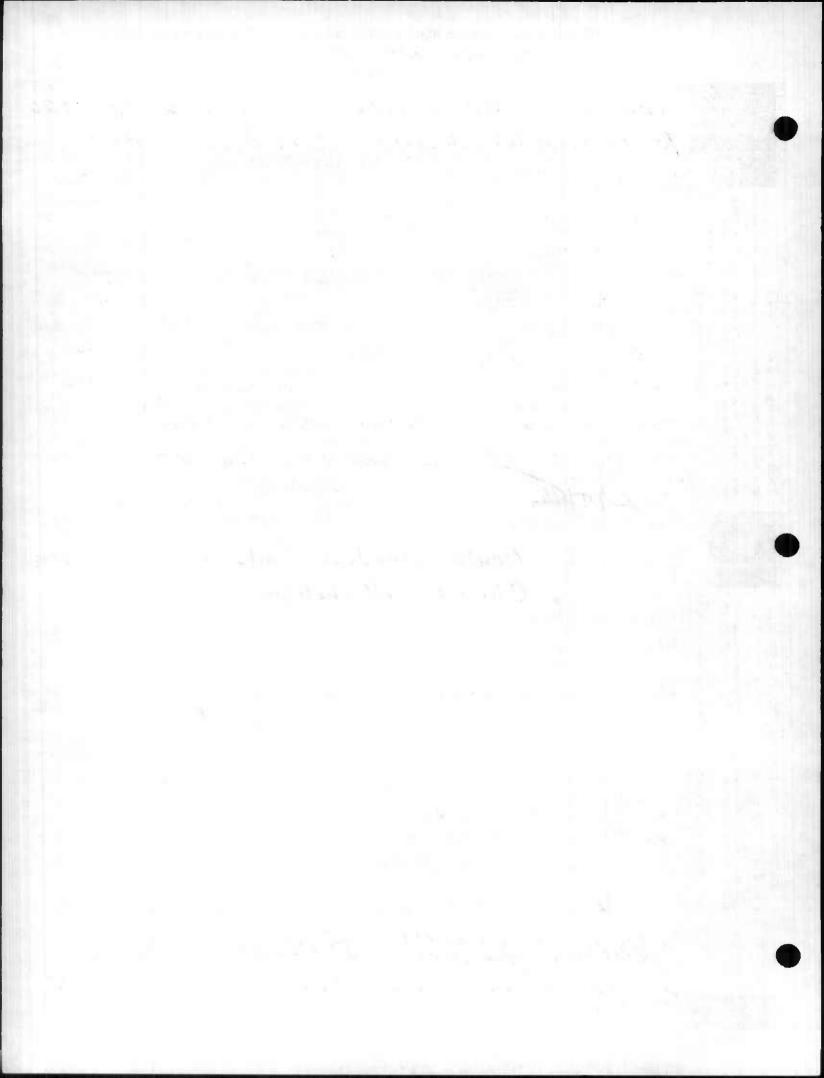


State of Maryland / Department of Health and Mental Hygiene 8

Certificate of Death

Reg, No.

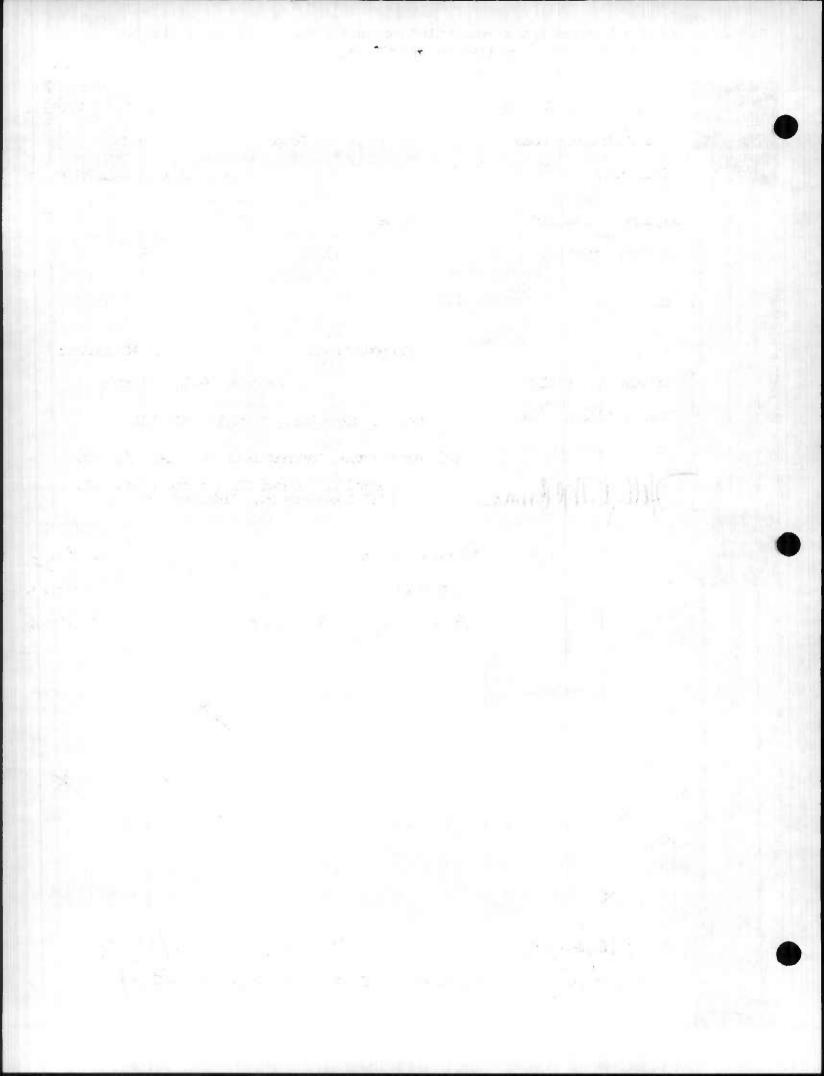
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State of Maryland / Department of Health and Mental Hygiene Q

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Examir		4e. Facility Name (If not institution, give	street and number)			4	lb. City, Town, or L		4c. County		
		16 Fort Hoyle	Road				Joppa		На	rford	
Funeral Director		5. Social Sacurity Number 6. Social Sacurity Number 183-10-5340 Usual Rasidance of Decedant		(In yrs. last birtho	Months	ar 1 Yaar Deys	if Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, Sept.	Yaar) 21,1912	9. Birthplaca Country) Penns	(State or Fore
ě w		10a. Stata 10b. County		10c. City, Town o	r Location					10d. i	nsida City Lim
23s or 28s-f show	ector	Maryland Harfo	rd	Jo	ppa						□Yas 2X
23a or 2	Funeral Director	16 Fort Hoyle Rd	•				085		0g. Citizen of N USA	What Country?	
natural, or items 23s or 28s-f show	by	11. Marital Status 1 □ Naver Married 2 □ Married 3 ☒ Widowad 4 □ Divorcad	12. Was Dacedant Ev Armed Forces? 1 ⊠ Yas 2 ☐ No If Yes, Give Yaar or Dates:	WII			ispantc Origin? (Sp in, Maxican, Puerto Specify:	pecify Yes or No- Pican, atc.)		e - Amarican Ir ck, Whita, atc. Whit	
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the the	Phys	Part II. Othar algniffcent conditiona co	ntributing to death but	not resulting in th	a undarrying	causa givi	an in Part I.	112 Y		ntribute to the 3 ☐ Probably	
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		Harford Memorial Hospital			Havre de			rford
Funeral Director		5. Sociel Security Number 215-34-6649 Usuel Residence of Decedent 5. Sociel Security Number 1 □ M 2 □ F 58	lest birthday) Yrs.	If Undar 1 Yaar Months Days		8. Date of Birth (Month, De) Jan. 8	, 1940 \	9. Birthplece (State or Ford Country) Virginia
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death with the Maryland ms 23s or 28s-f show	to	Maryland Harford	Churc	hville				1 □ Yes 2 🙀
or 28a-f	irec	10e. Street end Number		10f. Zip Code			10g. Citizen of Wi	hat Country?
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or he	by Funeral Director	11. Marital Stetus 1 □ Naver Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ② No If Yes, Give Yeer or Dates:		Was Decedent of I f Yes, specify Cub I ☐ Yes 2 ☐XNo	Hispenic Origin? (Spean, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		- American Indian, , White, etc.
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should be and Mental marked o	2	James Stuart Medley			Juanita		-	
hand hand is m		19a. Informent's Name/Reletionship (Type, Print)			t and Number or Ru			
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/Medical Examiner participation and participatio	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undartying Ceuse (Disease or Injury	or of 0 7 or es e consequence of 0 10 10 10 10 10 10 10 10 10 10 10 10 1	uence of 1950	love (To obst	ruction los	le le	mony y.
he death certificate be a the attending physician	Physician/Med	Part II. Other significant conditions contributing to death but not resi	por	0 21 440		23b. Did to	obacco uae conti	Several c
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month JAN cr hil

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0000	nours efter death with the Marylend	ural, or items 23a or 28a-f show L'Examiner must be notfred at	d by Funeral Director

thur al 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth el Baltimore City

If Under 1 Year If Under 24 Hrs. 8. Date of
Months Devs House Afficiance 6. John's Hopkins Hospital 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) 100M 2□ F Deys Hours Min. Yrs. 717-07-5591 84 06/25/1913 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location Funeral Director Harford Havre de Grace 10e. Street and Number 10f. Zip Code 825 Ontario Street 21078 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 20 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 end 2 should be filed within 72 h. Department of Health end Menlel Hyglene. Important: If item 27 la marked other than "natu any Injury or other traumetic avent, the Medical 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 11th Shop Foreman Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Arthur V. Mitchell, Sr. Anna Mae Osborne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) W. Lamar Hopkins- Brthr-in-law 2812 Emmorton Rd., Abingdon, MD Baltimore, 20a. Method of Disposition

1

M Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 4 ☐ Donation 5 ☐ Other (Specify) Rock Run Cemetery 22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. 21. Signature of Funerel Service Licenses Ham 123 S. Washington St., Havre de Grace, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physiclan** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit completely filled in by the turned director, page 2 should be detached for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initioted events resulting in death) Lest Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. by 24a. Was an autopsy performed? Completed 1 ☐ Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? Certification: 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tacartfying Phyaician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical 29b. Signati 29c. License number 29d. Date signed (Month, Dey, Year) D0052247 person who completed cause of death (Item 23a) (Type, Print) 17 Tol Holkins Gerratures POP 31. Date filed (Month, Dey, Year) 32/Aggistra a Stanature Randall

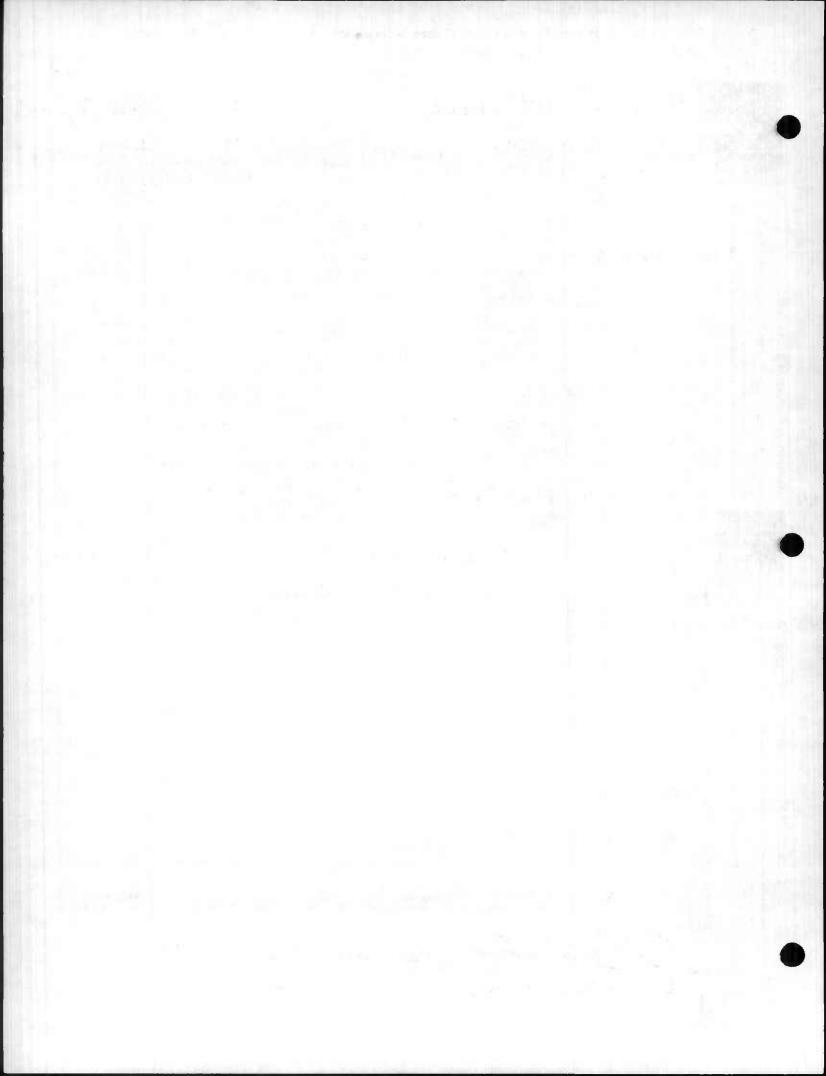
4c. County of Death Baltimore City Birthplace (State or Foreign Country) MD 10d. fnside City Limits 1 Yes 2 No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Government 21009 20c. Location - City or Town, State 1/16/98 Havre de Grace, MD Approximate Interval Between Onset and Death 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 20 No 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

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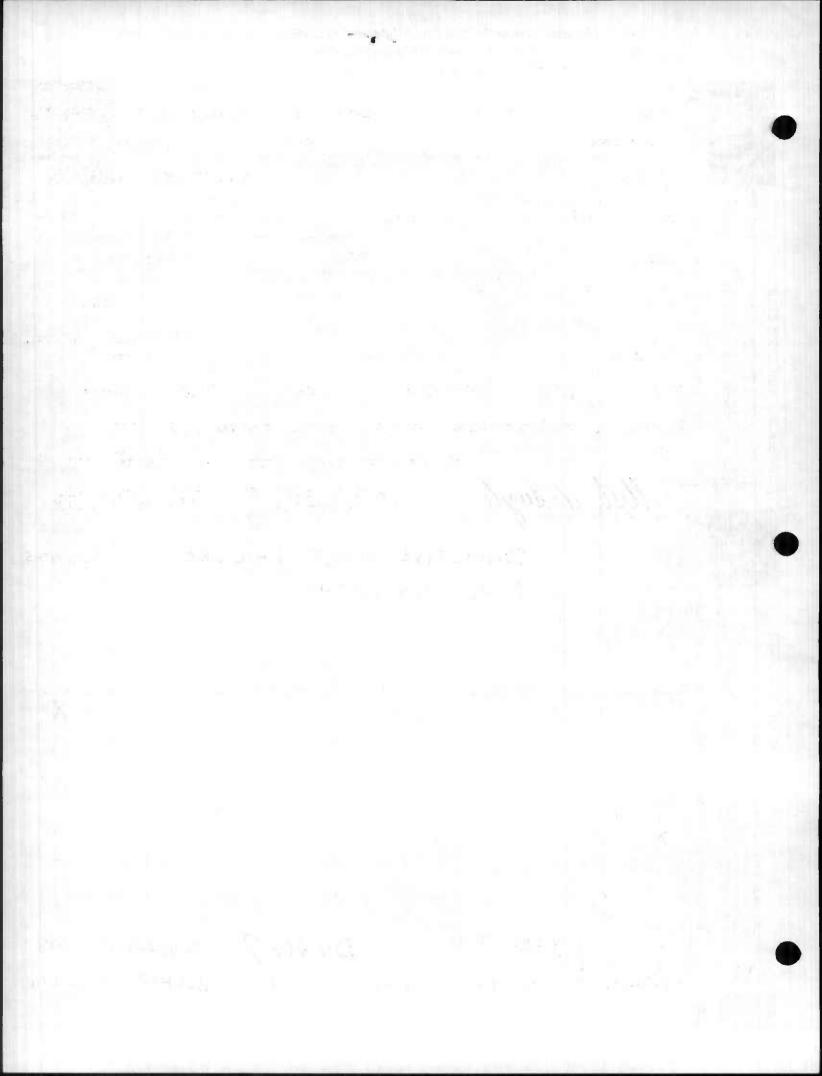
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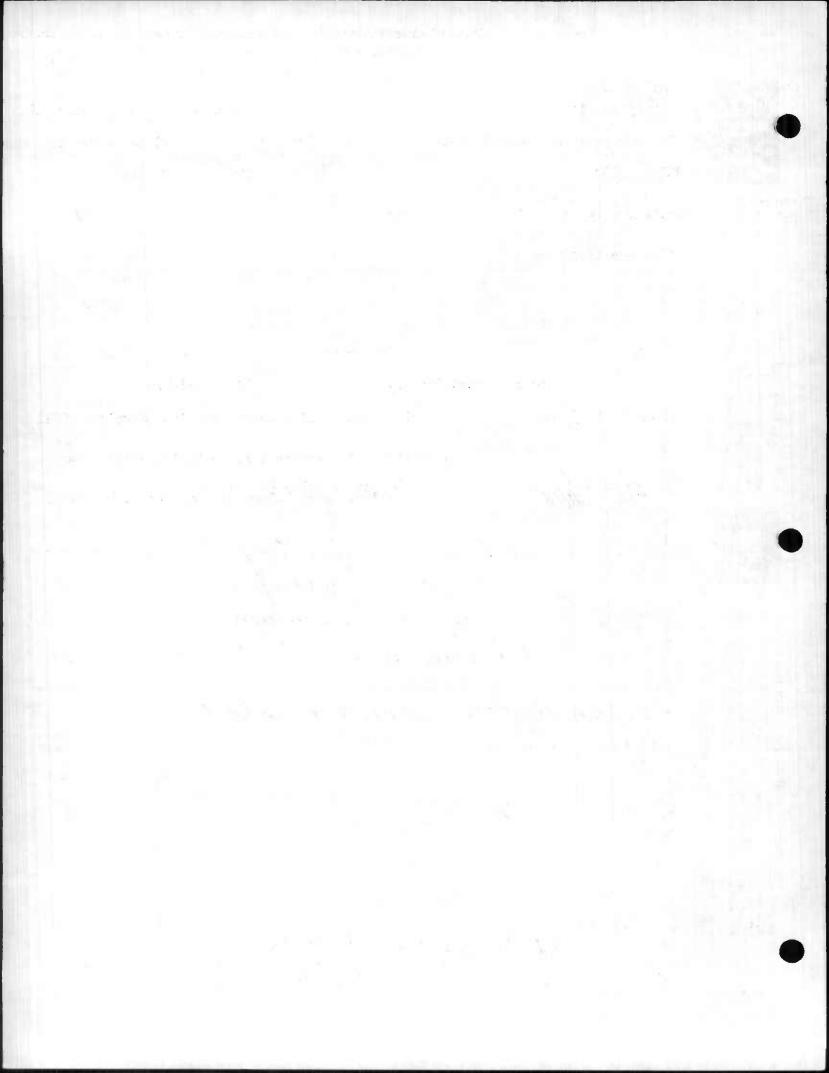
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led in by the funera Certification:		3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could datam	not be	28a. Place	of Inj	ury - At homa, fa	rm, stra	at, factory, office		28f. Locetion	(Street and I	Vum <i>ber or R</i> u	ural Routa Number,
e L		4 🖂 Homicide			DUNGI	ng, at	c. (Specify)				City or 1	own, State)		
i i i	1	29a. Certifier	1 Certifyi	ng Phy	sician: To tha	best	of my knowledge	, death	occurred et tha tir	na, data and plac	e, and dua to th	a causa(s) ar	id mannar as	stated.
complately filled in by the funeral director, Medical Certification: To Be ((Check only one)	2 Medical	Exami	ner: On tha ba	asis of	axemination and	d/or Inva	stigation, in my o	pinion, deeth occ	curred et the time	s, date end pl	ece, end due	to tha ceusa(s)
Me	2	29b. Signatura ar	litla of certifia	19	A		^		29c. Licans	a number		29d. Data s	signad (Monti	h, Day, Year)
•			In	10	W	m	· U ·		NL	1666	7	TANIA	ARY 1	5, 1998
	9	30. Nama and ad	drass of	who or	omplated source	a of a	eath /Item 22a\	Tune	(rint)	WWW		SHIVE		_ , , , , ,
	4	SYEKA	11	WIIO CO	1 / M	131	4 C	A F	RTH 1	WF #1	124 K	FIA	RI	nD21014
Choto	3	31. Dete filed (Mo	onth, Dav. Year	5	A2 R	enistr			1-111	1.0 75	1 1	50011	-	
State gistrar		1.0			Julia	dia	ar's Signaty	lall,						
egistrar			N16 1	398	July	AU IU	BUILDEN - BUILDE	4						

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State of Maryland / Department of Health and Mental Hygiene 98 02131

			A Dandard Name (Carl Milde)	-0		Certific	ate of	Death		Reg. No.		
П	Physic	ian	Decedent's Name (First, Middle, Last	St)					2. Data of I Month	Death Day	Yeer	3. Time of Deeth
	/Medi		Ruby I. Nitz						Janua		998	10:25 P.M.
	Exami	ner	4a. Fecility Name (If not institution, give					4b. City, Towr	n, or Location of De	ath 4c. Coun	ity of Death	
			Prince George's		Center			Cheve		Prin	ice Ge	eorge's
	Funeral		5. Social Security Number 6. S	DM off	(In yrs. last i	Monti	der 1 Yaar ns Days		Min. (Month,	Birth Day, Year)	9. Birth	placa (State or Foreign ntry)
	Director		231-44-0107	OW ZEF	76	Yrs.			Feb.	23, 1921	Kent	ucky
	pu ,		Usual Residence of Decedent		40. Oh. T.							
	show		Monry Land Amna Arra			wn or Location					1	10d. Inside City Limits
	W THE	cto	Maryland Anne Aru	mder	rage	water						NOXYes 2 No
	라 22 라	ire	10e. Street end Number			10f.	Zip Code			10g. Citizen o	What Cour	ntry?
	23a	aic	1713 Quantico Ro	ad			21	037			USA	
	ours after death with the Marylen elf, or items 23a or 28e-f show Examiner must be northed at	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	var in U,S.	13. Was De	cedent of	Hispanic Orlgin	n? (Specify Yes or I Puerto Rican, atc.)		ace - Americ	
0	after a		1 Never Married 2 Married	1 Tyes 2XXN	0				Puerto Hican, atc.)	BI	lack, Whita,	atc.
02	al',	by	3√XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 Li Yes	SFYNO	Specify:		Spec		ite
21215-0020	n 72 hours after death with the Maryland *natural', or items 23a or 28a-f show solical Evantinet must be notified at	Completed	15. Decedent's Ed	ucetion	16	a. Decedent's U	sual Occu	pation		16b. Kind of		
2	within 7 ene. then *n	pie	(Specify only highest grade Elementery/Secondary (0-12)	completed) College (1-4or 5-	N	life. DO NO	work done Tuse retire	during most o	or working			
2	77 77 10	E O	9th	College (1-401 34	"	Home	make:	r			Hom	ie
	be filed Ital Hygi d other	Bec	17. Fathar's Name (First, Middle, Last)						s Name (First, Midd	lle, Maiden Suma		
a		ToB	J	ames Leona	ard Bar	ctlev			Linda	Wright		
Maryland	M br	-	19a. Informant's Name/Relationship (7				ess (Stree	t and Number	or Rural Route Nur		m. State. Ziu	n Code)
Š	d 2 al		Ralph E. Nitz/ Sc									and 20711
e,	nit. Peges 1 and 2 should artment of Health and Mer ortant: if Item 27 la marka injury or other traumatic 8.		20a, Method of Disposition						Date	20c. Location		
0	Peges nent of nt: if its iry or o		1 X Burial 2 ☐ Cremation 3 ☐			of Disposition (fi					*	
	tant Jury		4 Donation 5 Other (Specify		Laken				s 1–12–98	Davidso	nvill	e, Maryland
Baltimore	permit. Pege Department of Important: If any Injury or once.		21. Signature of Futheral Seofice Liber:	566		George George	and Addr	Kalas	Funeral F	Homo		
	2026 a		· 1000 0 1000	7		2973	Solor	nons Is	Funeral Hand Rd.	Edgewat	er. M	d. 21037
			23a. Part ¹ . Enter the disease, or comp shock, or heart failure. List only	olications that ceused tone cause on each line	the daath. Do	not enter the m	ode of dy	ing, such as ce	erdiac or respiretory	errest,		Approximate Interval Between Onset and Death
F	Physician		0.	4						4	1	Onset and Death
ı.	/Medical		Immediate Causa (Final disaasa or condition	A	eesto	2 80	286	crat	our of	ailon	0	minute
l '	Examiner		disaasa or condition resulting In death)	a	Due to (or as	a consequence	n. 1/					. , , , , , , , , , , , , , , , , , , ,
Ш.,	n =	ner		000	rito	h	MM	cho s	chain	1	1	few day
	cate be executed physician and s the burial-transit	Examiner	Sequentially list conditions.	b	Due to (or as a	a consequance of			1			700000
ó	ificate be execut g physician and as the burial-tran		Sequantially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury	(:	2000	to 1	mo	zem o	2110		į	don Am
68760,	ysicii e bu	edicai	that initiated avents	c	ue to (or as a	consaquande			mes.			Terr any
89	g ph as th	e	resulting In death) Last	00	-			elli	0 12	~ M.		1/20
Rox		2		d. Chris	ne	Clu	ein	eeuv	+ yew	of due	le	Joseph
ά	d for	icia	Part II. Other aignificent conditions co	merikusing to double hus		In the contest de		con in Dani I	025 0	/ 		o the cause of death?
0.	requires that the death cer seen signed by the ettendir hould be deteched for use	Physician/N	O a granical conditions co	and and and and and and and and and and	Not resulting	an the underlyin	y ceuse gr			. /		
1	that hed to	by P	Cardiae	apothon	ua y	alle	Ne	Brond	hilee "	Yes 2□ No	3 FIO	bably 4 Unknown
Vital Records,	uires sign	g p	luce of	0 1					24a. W	as en eutopsy	24b. W	/ere eutopsy findings
Ö :	been s	Completed	righer leu	bron.					pe	rformed?	ev	reliable prior to empletion of cause
Je .	2 8 2	mp	0								of	death?
<u> </u>	cate .								1(Yes 2000	1[☐ Yes 20 No
	Physician: The tribis certificate and director, page	Be	25. Was cese referred to medical examiner?	Unicolarly and			10		f Death (Check onl	y one)		
0	Physic this c	5	HIES ZINO	Hospital: 1 Inpatien		Outpatient 3	DOA		ing Home 5□ Re	sidence 6 🗆 O	ther (Special	fy)
_	ng P	:uo	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury	28c. Inju	ry at rk?	28d. Describ	e how injury occi	urred	
9	Attending ir death. actor: After by the fune	ati	2 Accident Investigation			М	1	Yes 2□No				
Division	Pr de de de de de de de de de de de de de	tifi	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.	y - At home,	farm, street, fac	ory, office			(Street and Nun own, State)	nber or Run	al Route Number,
5	ed in Dia	Certification:		January 3, 5151	(,,		
	hour Inera		29a. Certifier 1 Certifying Phy	alclan: To the best of	my knowledg	ge, death occurr	ed at the ti	me, date and p	place, and due to th	ne cause(s) and r	nanner as s	stated.
	To the hospital or attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical Examone)	iner: On the basis of e and manner stet	examination a ed.	nd/or Investigati	on, in my	opinion, death	occurred at tha tim	e, date and place	, and due to	o tha causa(s)
4	Vithii To th	X	29b. Signature and title of certifier				29c. Licen	sa number		29d. Data sign	ad (Month,	Day, Year)
ı İ			for	104.7	00 1	an	100	247.	20	1-	08-	-98
			30. Name and eddress of person who c	ompleted cause of de-	ath Utam 23a) (Type, Print)	120	DAS	4410			
			6132 10	udaras	SP	ne d	CI	MAN	MOER R	12 5	178	[Nel
	Sta	ite	31. Date filed (Nonth, Day, Kear)	32. Registrar	Signature	4			J	-a w	100	
	Registr	_	JAN 12 1338	4 scha L	QIHAMA.	Mandoll.						



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 1998 GEORGE WALTER PHELPS 7:02 AM JANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deal Examiner If Under 24 Hrs. Hours Min. HURNE ANNE HOSTITAL ORTH RUNDEL RUNDEL If Under 1 Year Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days WEST VIRGINIA 1 M 2 F 78 Yrs. 234-26-0522 Director MAY 9, 1919 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Medical Examiner must be righted at MARYLAND ANNE ARUNDEL Director GLEN BURNIE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 109 NORMAN AVENUE 21060 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? XX Yes 2 □ No 1945— If Yes, Give 14. Race - American indian, Black, White, etc. Was Decedent of Hispanic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ₩ No If Yes, Give Year or Dates: Specify: WHITE 2 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n end Mental Hygiene. Is merked other than College (1-4or 5+) Elementary/Secondary (0-12) N/A 12 BUILDER & DEVELOPER CONSTRUCTION PHELPS, permit. Pages 1 end 2 should be file Department of Health end Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event page. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) FLMER PHELPS MABEL JOHNSON P 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS PHELPS (SON) 109 NORMAN AVENUE, GLEN BURNIE, MD. 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 14 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK 1/9/98 GLEN BURNIE, MD. Funeral Service License 22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 ada Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Abdominal Aprtic Aneurysm 10 days Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician end the bunel-tran Due to (or as e consequence of). Box 68760, Physician/Medical Due to (or es e consequence of): 98 ettending p signed by the et d be deteched for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed been hes page 2 1 ☐ Yes 2 100 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 DNaturei 5 Pending investigation death. 1 Yes 2 No Hospital or Attendi 24 hours efter death. Funeral Director: A 2 Accident 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours e 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as steted. edicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00085 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUST STINZ GLEN BURNIE, MD 21061 JATISZOH EOS MARC OKUN MD DRIVE 31. Date filed (Month, Day, Year)

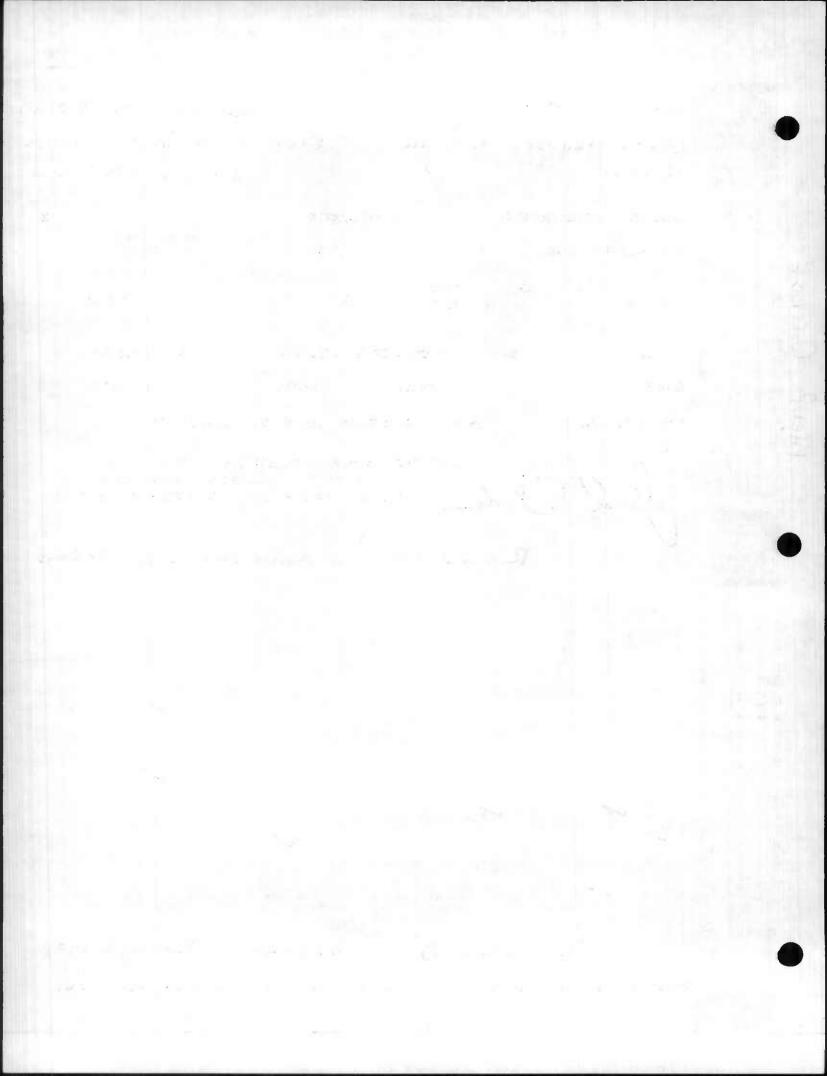
JAN 13 1998 32. Registrar's Signature State

who Davidson

Registrar

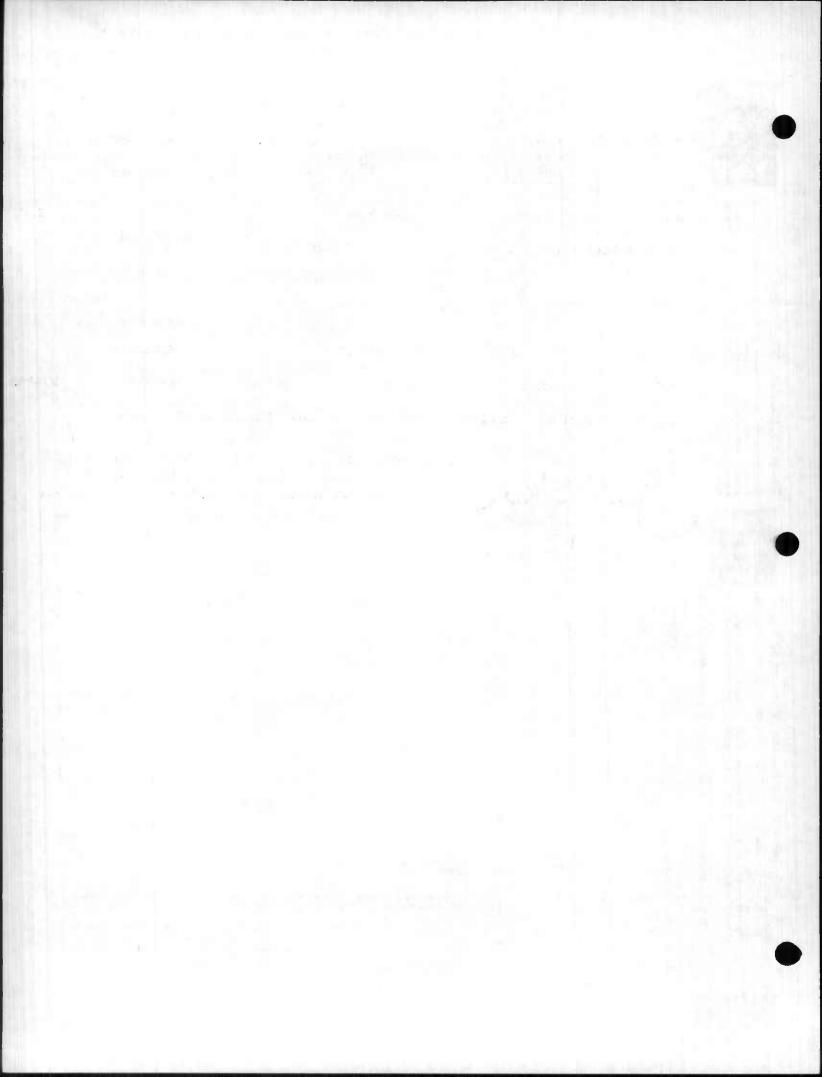
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GEORG



State of Maryland / Department of Health and Mental Hygiene 8

				Ce	rtificate of			Reg. No.	02133
Physic /Med		1. Dacedant's Nema (First, Middle, La	Gerala	,	Pay	ne, Sr.	2. Data of Das Month	Day \	3. Tima of Death Year 7 · 15 PM
Exami		4a. Fecility Nema (If not institution, giv	The state of the s			4b. City, Town, or	Location of Deeth	4c. County of	Daath
Funeral Director		NORTH ARUNDEL HO 5. Sociel Sacurity Number 6. S 216-24-1268	Sax 7. Age (In yrs.	last birthday) 69 Yrs.	If Under 1 Year Months Deys		8. Data of Birt	h v. Yaar)	ARUNDEL 9. Birthplaca (Stata or Foraign Country) 1ARYLAND
ס		Usual Rasidance of Decedant 10a. Stata 10b. County	10- 0	Table 111				, =====	
e Meryla 8a-f shov	Director	MARYLAND ANNE A	ARUNDEL 10c. Cr	ty, Town or Lo	N BURNIE				10d. Inside City Limits 1 ☐ Yas 2 🖺 No
oth with the 23a or 2	rai Dire	10e. Street and Number 108 SANDSBURY AVE	IUE		10f. Zip Coda 210	60		10g. Citizen of Wh U.S.A	nat Country?
d within 72 hours after deeth with the Menjand within 72 hours after deeth with the Menjand plane. I than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Navar Married 2 □ Married 3 █ Widowed 4 □ Divorced	12. Was Decedant Evar In U Armad Forces? 1∑Yes 2□No 195 If Yas, Giva Yaar or Dates: 195	50-	Was Decedant of If Yas, specify Cul 1 ☐ Yes 2 ☐ No	Hispenic Origin? (S ban, Maxican, Puer Specify:	Specify Yes or No- to Ricen, atc.)	14. Race - Black, Specify:	- Amaricen Indian, Whita, etc. WHITE
	Completed	15. Decedant's Ec (Specify only highast gra Elamentary/Secondery (0-12)	da complated) College (1-4or 5+)	(Giva lifa.	dant's Usual Occu a kind of work dona DO NOT usa ratire FITTER	during most of wo	rking	16b. Kind of Busi	
be filed within tal Hyglene. d other than "		9 17. Fethar's Name (First, Middle, Last,	N/A	PIPE	FILLER	18. Mother's Na	ma (First, Middla,	Meiden Sumama)	
should be a Mental marked o	To Be		OREW	PAY	NE	MARY		BEVERLY	
e, Mal ylar ylar ylar ylar 1 and 2 should Health and Men am 27 ls merke wher traumatic		19a. Informent's Name/Ralationship (KATHLEEN P. SWEEN)				cove, co			
permit. Pages 1 and Deperment of Healt Important: If Itam 27 any Injury or other once.		20a. Mathod of Disposition X□ Burial 2 □ Crametion 3 □ 4 □ Donation 5 □ Othar (Specification)	Ramoval from Stata	cematary, crei	osition (Nama of metory or other pla OSS CEMET		Data 1/16/98	20c. Location - Ci	ity or Town, Stata I PARK, MD.
permit. Depertmine importa any Injures		21. Signature of Funary Service London		22	2. Nama and Addr	ass of Facility S			HOME, E, MD. 21061
_	(23a. Part1 Entar the disaasa, or com shock, or haart failura. List only	plications that causad the deet						Approximata Intarval Batwaen
Physician /Medical		Immedieta Causa (Finel disaasa or condition		ance					Onset and Death
Examiner	-e	rasulting in death)	Due to (c	or as a consec	quance of):	-			3 weeks 3 weeks 10 days.
cuted	edical Examiner	Sequantially list conditions.	b. Pneumo	or as a consec	quence of):) weeks
ficete be axecuted i physician and is the burial-trensit	al Ex	Sequantially list conditions, if any, laeding to Immadiata ceuse. Entar Undarlying Ceuse (Disaase or Injury that initietad evants	· Pulmon			lism			lo days.
entificate ding phys	Medic	that initieted evants rasulting in death) Lest		ras a conseq					
ettano	ician	Dod II. Ohno slauktingst og stalen.					1		
as that the death cer igned by the ettandir be detached for use	Physician/M	Part II. Other algolificant conditions of	ontributing to death but not res	ulting in tha u	indariying ceusa gi	iven in Part I.			ibute to the cause of death? B Probably 4 Unknown
The lew requires that the death certificate be axecuted ate hes been signed by the ettending physician and page 2 should be detached for use as the bunal-trensit	leted by						24a. Was a		24b. Wara autopsy findings available prior to completion of cause
ysician: The law is certificate hes director, pege 2	Completed						1 🗆 Y	as 200 No	of deeth?
slan: artifica octor, p	Bec	25. Was casa raferrad to medical axaminar?					eth (Check only o	na)	
hysic this co	2	1 ☐ Yas 2 ☐ No		ER/Outpetier	IN SLI DOA			ence 6 □Other	
Attending Physician: or death. bottor: After this certific by the funeral director,	tion	27. Mennar of Death 1 Natural 5 Panding 2 Accident Invastigation	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	Wo	iryat ork?]Yas 2∐No	28d. Dascribe h	ow injury occurred	3
To the Hospital or Attending Physician: T within 24 hours after death. To the Funeral Director: After this certificat completaly filled in by the funeral director, p	Certification:	3 Sulcide 6 Could not be detarmined		oma, farm, str y)			28f. Location (S City or Tow		or Rural Routa Number,
Hospitu 24 hours Funeral	edicai C	29a. Certifier 1 Certifying Ph	yalcian: To the bast of my kno niner: On the besis of axamine end mannar stated.	wledga, daath tion and/or In	h occurred et tha ti vestigation, in my	ima, data and place opinion, deeth occu	e, and dua to tha curred et tha time, c	ausa(s) end mann lete end place, en	nar as stated. d due to tha ceusa(s)
To the To the	Me	29b. Signatura end titla of certifier Sherif Elesce			100000000000000000000000000000000000000	sa number			Month, Day, Year)
		30. Nama and address of person who as Sherif Elass D. A		n 23a) (Type,	Print)	333644	LA Driv	0 Gon-	Ruraio un sier
		Sherif Elassa N 31. Data filed (Month, Day, Yaar)				SOL HOSIS	Lan Tria	C GIEN	DUTTIE, MD 2108
Sta	ite	IAN 1 3 1998	32. Registrar's Signa	A Brand	00-				

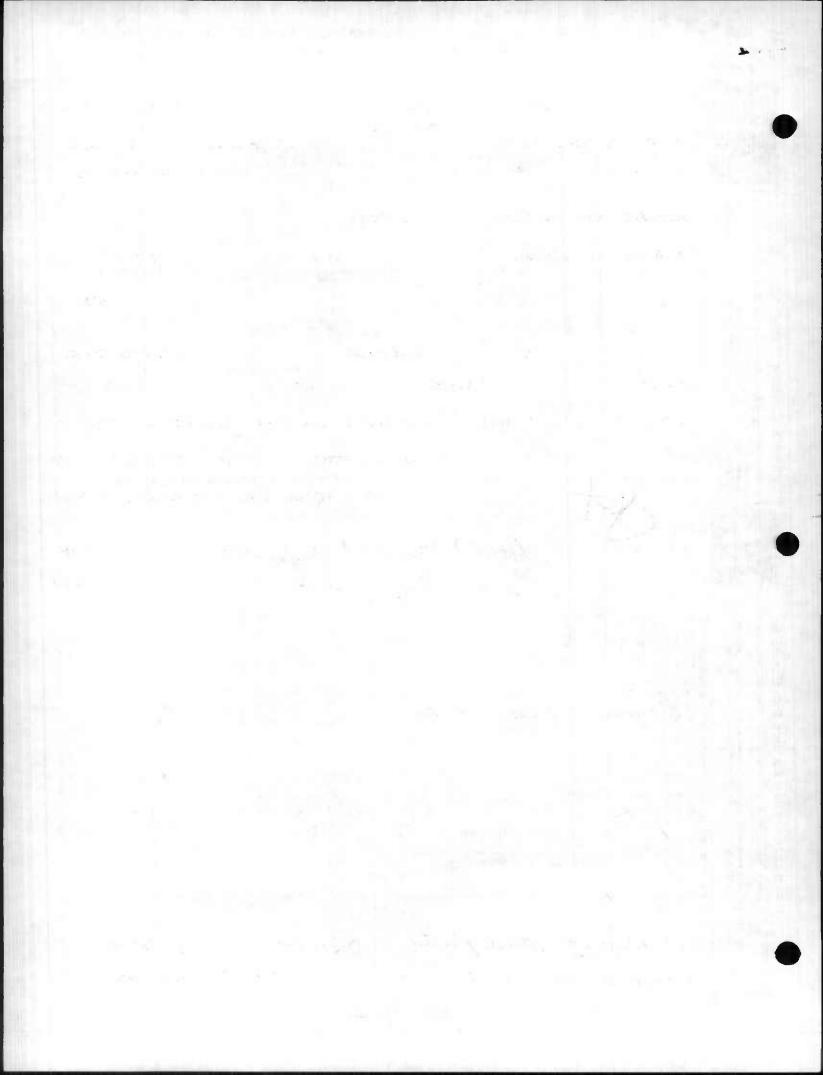


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

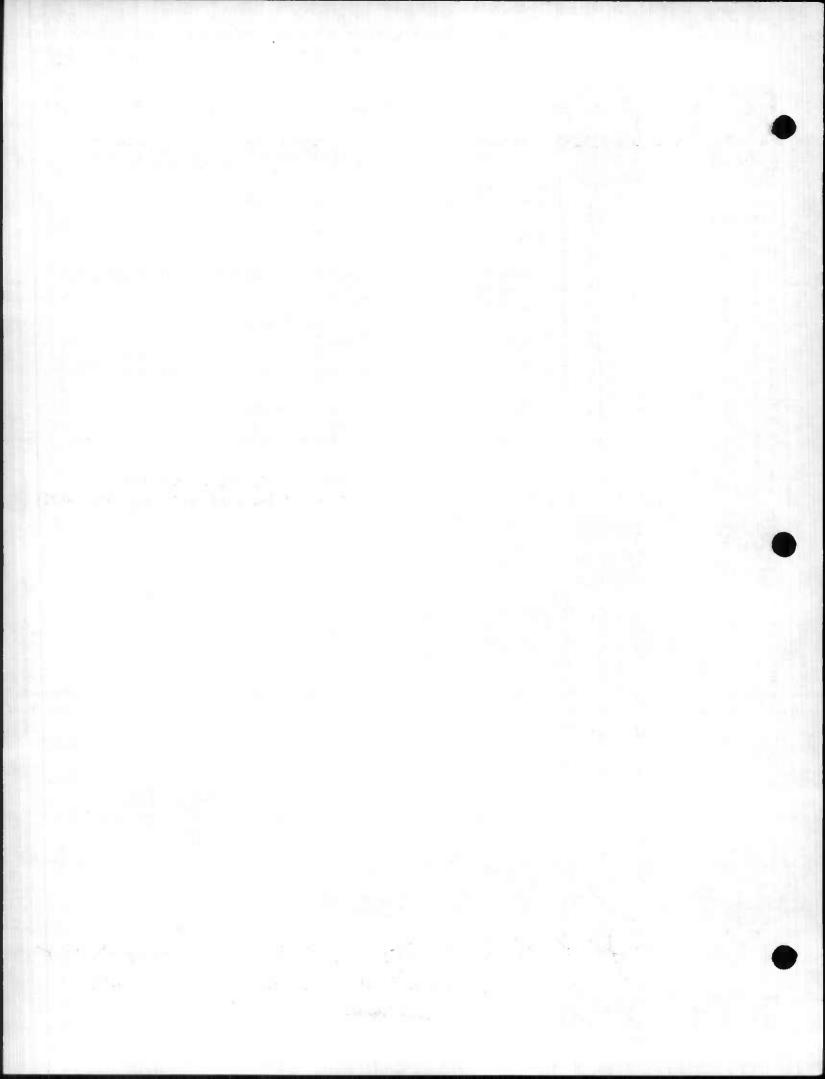
Reg. No. 98 02 1 3 4

					Cert	ificate of	Death	R	eg. No.	UZ	134
Physici	an	1. Decedent's Name (First, Middle, L	ast)					2. Date of Deat Month	th Dev	Year	3. Time of Dee
/Medic			ANNA		TRAS			JANUARY			9:00 AM
Examir Funeral Director	ner	4a. Facility Name (If not institution, g CENTER GENESIS E 5. Social Security Number 218-09-0998 Usual Residence of Decedent	LDERCARE	e (In yrs. lest bir	thday)	NE If Under 1 Year Months Deys		N PARK 8. Date of Birth (Month, Dey,		9. Birthple	ace (State or For
/land		10a. State 10b. County		10c. City, Tow	n or Loca	ition				10	d. Inside City Lir
a-f sh	tor	MARYLAND ANNE A	RUNDEL	L	INTH	ICUM					1 ☐ Yes 2 🔀
ter death with the Marylan Items 23a or 28a-f show Iner must be notified at	al Director	10e. Street and Number 6428 ENGLISH OAK	COURT			10f. Zip Code 210	90	1	0g. Citizen of	What Count	ry?
0 0 5	by Funeral	11. Marital Stetus 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 14 If Yes, Give Year or Dates:			as Decedent of yes, specify Cub	Hispanic Origin? (Spen, Mexican, Puert	pecify Yes or No- o Ricen, etc.)		ce - Americe ck, White, e	
72	Completed	15. Decedent's I (Specify only highest g		16e.	(Give kir	nt's Usuel Occu	during most of wor	king	16b. Kind of B	usiness/Indi	ustry
d within plene. r then	mpi	Elementary/Secondary (0-12)	College (1-4or 5		life. DC	NOT use retire	ed)		a s D	Mpr pr	
77 77 14		17. Father's Name (First, Middle, Las		5	UPER	VISOR	18. Mother's Nar	ne (First, Middle, I	C & P Malden Sumen		PHONE
d 2 should be filed the end Mental Hyg	To Be	JOSEPH		POLAK			MARY	A.]	RASKA	
2 shou end M is mer	-	19a. Informant's Name/Relationship	(Type, Print)	19b	. Mailing	Address (Stree	t end Number or Ru	rel Route Number	, City or Town,	Stete, Zip (Code)
ロ南のド		EDWARD P. PETRA	ASKA (SON)	64	28 E	NGLISH	OAK COURT	, LINTHI	CUM, MI	0. 210	90
		20a. Method of Disposition **Durial 2 Cremation 3 4 Donation 5 Other (Spec		cemeter	ry, creme	tion (Neme of story or other pla S CEMET			BROOKL	-	
permit. Page: Department of Important: If i any Injury or once.		21. Signature of Paneral Gervice Lice	ensee				ess of Facility SIN				
sertificate be executed Sing physician end Se es the burlel-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Lest	c	Due to (or as a o	conseque	ence of):	eari				1400/
oeath ce ne attandii ed for use	cian	Part II. Other aignificant conditions					Park	oos Dida-			46
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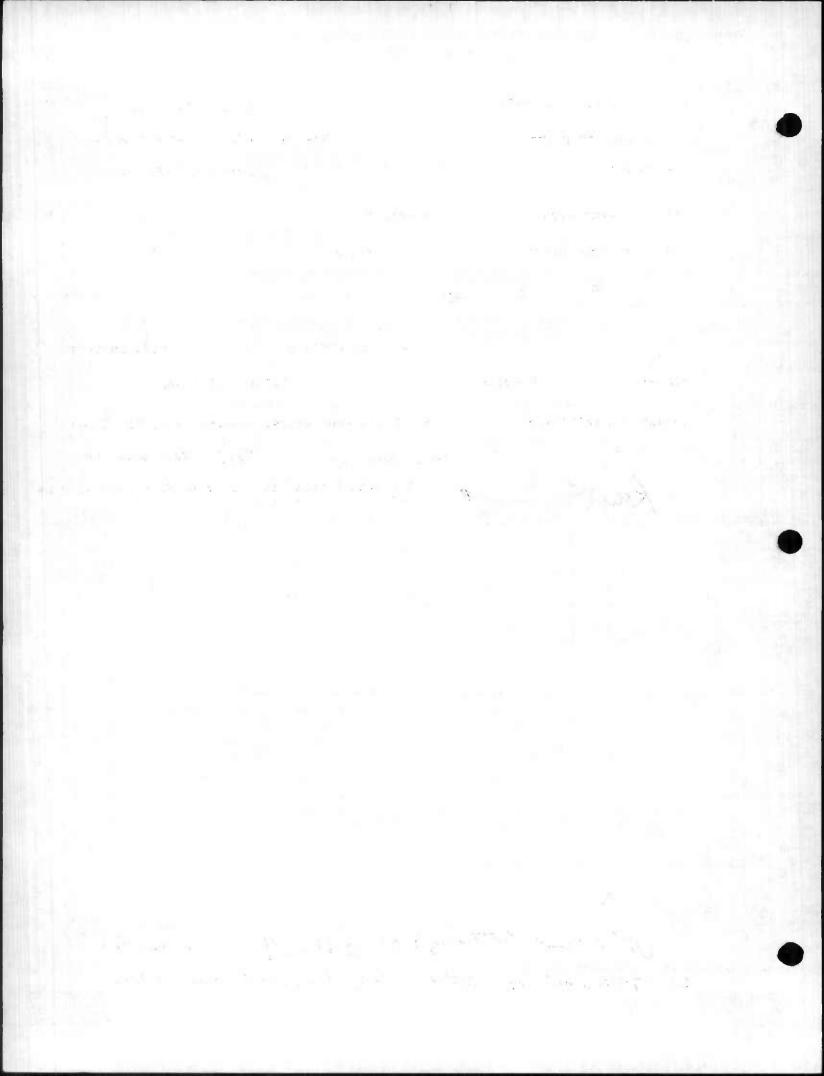
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ath with th	Vast De na		10e. Street and Number 17512 Old Baltimo	ore Road			10f. Zip Code 2083			Og. Citizen of V United of Ame	States	S
ire, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours efter death with the Maryland f Health and Mentel Hygiene. Item 27 la marked other than "natural", or items 23a or 28a-1 show the present of the part of th	Examiner	by Fur	11. Marital Stetus 1 ☐ Naver Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces' 1 Yas 20 If Yes, Give Year or Datas:			as Decedent of Yas, specify Cut		Specify Yas or No- to Rican, etc.)		e - Amarican k, White, etc	2.
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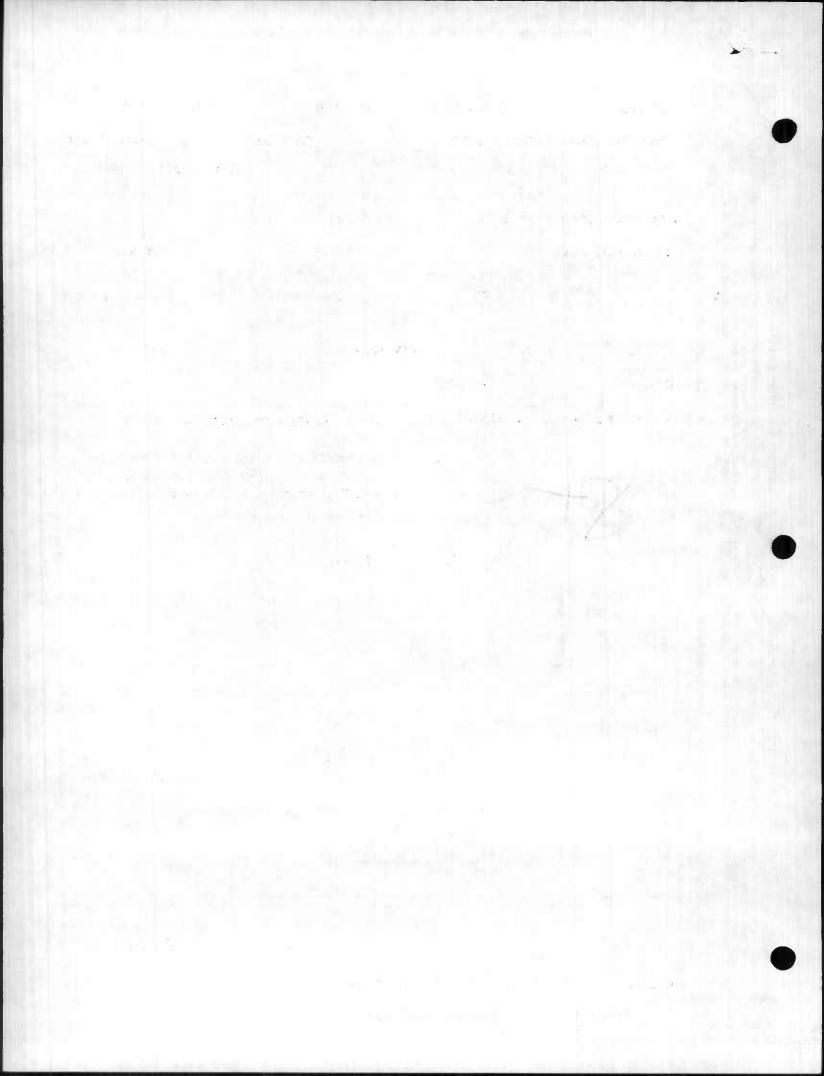
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Funeral Director		5. Sociel Security Number 6. Se 236-20-4025	7. Age (In yrs. lest	t birthday) If Under 1 Ye Yrs. Months Day		8. Dete of Birth July 19	Year) 9. B	irthplece (Stete or Foreigr Country) DW a
yland		Usuei Residence of Decedent 10e. State 10b. County		Town or Location				10d. Inside City Limits
h the Maryland r 28a-f show Inotified at	ctor	MD Anne Aru	idel S	everna Park				1 ☐ Yes 21公 No
2 2	Funeral Director	10e. Street end Number 847 Cottonwood Dri	ive	10f. Zip Code 21146		1	0g. Citizen of Whet 0	Country?
ter das Rems	by	11. Maritel Stetus 1 ☐ Never Merried 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give WWII Year or Detes:	13. Wes Decedent of if Yes, specify C	of Hispanic Origin? (Sl uben, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - An Bleck, Wh Specify:	nerican Indien, lite, etc. White
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death c	clan							
thet the death cented by the attendition of the detection of the attendition of the testing of t	/ Physician/	Pert II. Other significant conditions cor	tributing to death but not resultin	ng in the underlying cause	given in Pert I.	23b. Did to	1	te to the cause of death Probably 4 🗆 Unknow
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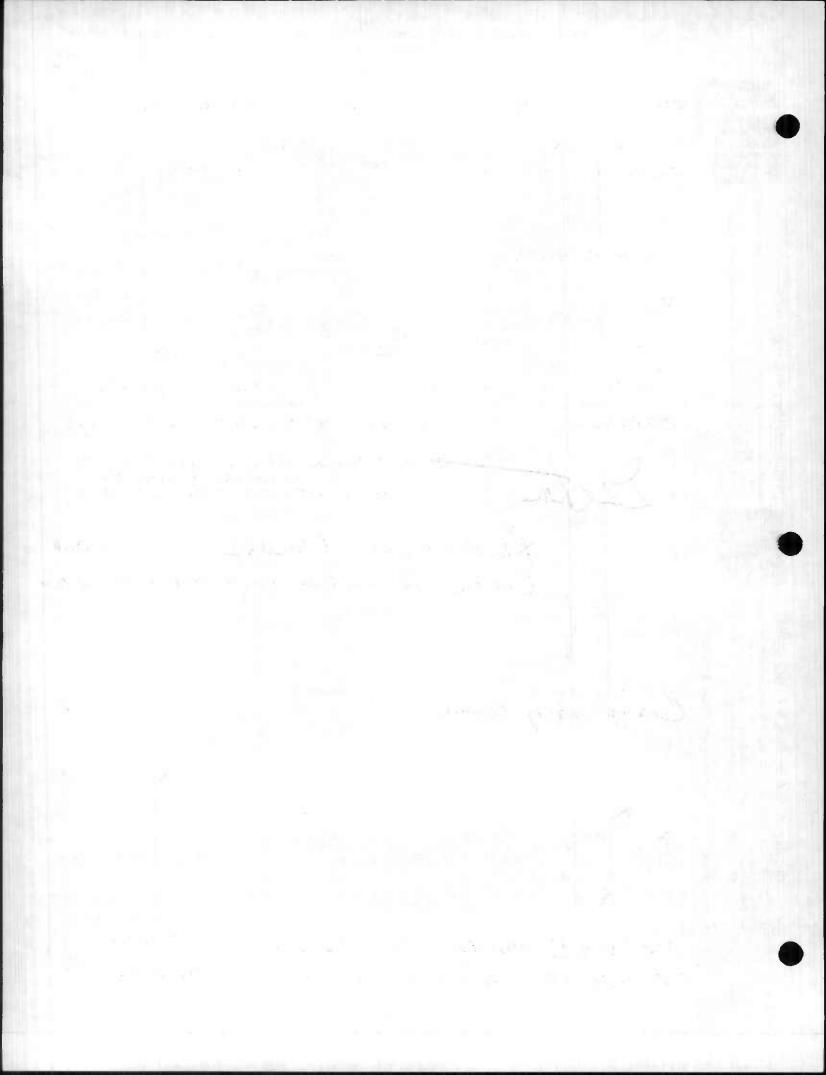
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State of Maryland / Department of Health and Mental Hygiene 8

					Ce	rtificate (of Death		Reg. No.		2100
Dhuois	nian	1. Decedent's Name (First, Middle, Le	- 4					2. Dete o		Yeer	3. Time of Death
Physic /Med		EDWARD	THOMAS			SMITH		JANU		1998	6:18 PM
Exam		4e. Facility Neme (If not institution, given NORTH ARUNDEL HO		mber)				wn, or Location of D N BURNIE	eeth 4c.	County of Deeth	UNDEL
Funera Director		5. Sociel Security Number 6. 9 212-20-0511	Sex M∑M 2□ F	7. Age (In yrs. le	ost birthday) 74 Yrs.	If Under 1 Y Months Do	aar If Undar eys Hours		Birth Dey, Year 7, 1923	9. Birth	npleca (Steta or Foreign NSYLVANIA
Maryland f show	or	Usuel Residence of Decedent 10a. State 10b. County MARYLAND ANNE AR	RUNDEL	10c. City,	Town or Lo	ocation LLERSVI	LLE				10d. Inside City Limits
with the Market	Director	10e. Street end Number 769 SOUTH MESA RO				10f. Zip Cod				en of Whet Co	
eath rs 23	eral	11. Marital Status	12 Was Doo	edent Evar in U,S	101	Man Decodes		gin? (Specify Yes o	- N - 1	4. Race - Amer	ing to the
d within 72 hours efter death with the Maryland Jiene. r than "neturel", or frems 23a or 28a-f show the Macical Evarrine must be notified at	by Funeral	1 □ Navar Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armad Fo	orces? No va		If Yes, specify (Cuban, Mexicen	gill (Specify 1930), Puerto Ricen, etc.)	Bleck, White	
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within ene. than	Completed	Etementery/Secondery (0-12)	Cotlege (life. i	DO NOT use re	etired)	. or working	(D)	RUCKING	
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permit. Pages 1 an Department of Heal Important: If Itam 2 any injury or other onte.		20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specification)		State Car	matery, crer	esition (Neme on netory or other EN MEMO	place)	Date RK 1/7/98	1	cation - City or I	
permit. Page Department or Important: If I any injury or		21. Signeture of Funeral Service Licer	1866	5				SINGLETO			
Physician		23a. Party Enterthie disease, or com shoot, or hand fallure. List only	plicetions that cone ceuse on e	caused the death.							Approximata intervel Between Onset and Death
/Medical Examiner		Immediate Caus (Finel disease or carrition resulting in deeth)	ө	Lyoc	ar	dial	Fn	farct	ron		1 hour
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certificate be executed ding physician and ise es the buriel-trensit	edicai Examiner	Sequentially list conditions, if eny, laading to immediata cause. Enter Underlying Ceuse (Disease or Injury	C	Due to lor	es a conseq	quence of):					
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0 0 0	Physician	Part II. Other significent conditions of	ontributing to de	eath but not result	ting In the u	nderlying ceuse	given in Part I.			/	to the cause of death
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ls certificate director, peg	Be	25. Wes cese referred to medicel axaminer?						of Death (Check o	nly one)		
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within 24 hours after To the Funeral Direction	edical	29a. Certifier (Check only one) 1 ✓ CertifyIng Ph 2 ☐ Medical Exam	niner: On the ba	best of my knowl asis of examinetic ner steted.	edge, death on end/or inv	occurred et the restigetion, in n	e time, date end ny opinion, deat	d place, end due to th occurred et the th	the ceuse(s) one, dete end p	end menner es place, end due	steted. to the cause(s)
withir To th	Me	29b. Signature end title of certifier	C (a	ul 1			ense number	50		signed (Month	
		30. Neme end eddress of person who	completed ceus	se of death (Item 2	23e) (Type,	Print)	-14	57	10	(0)	1110
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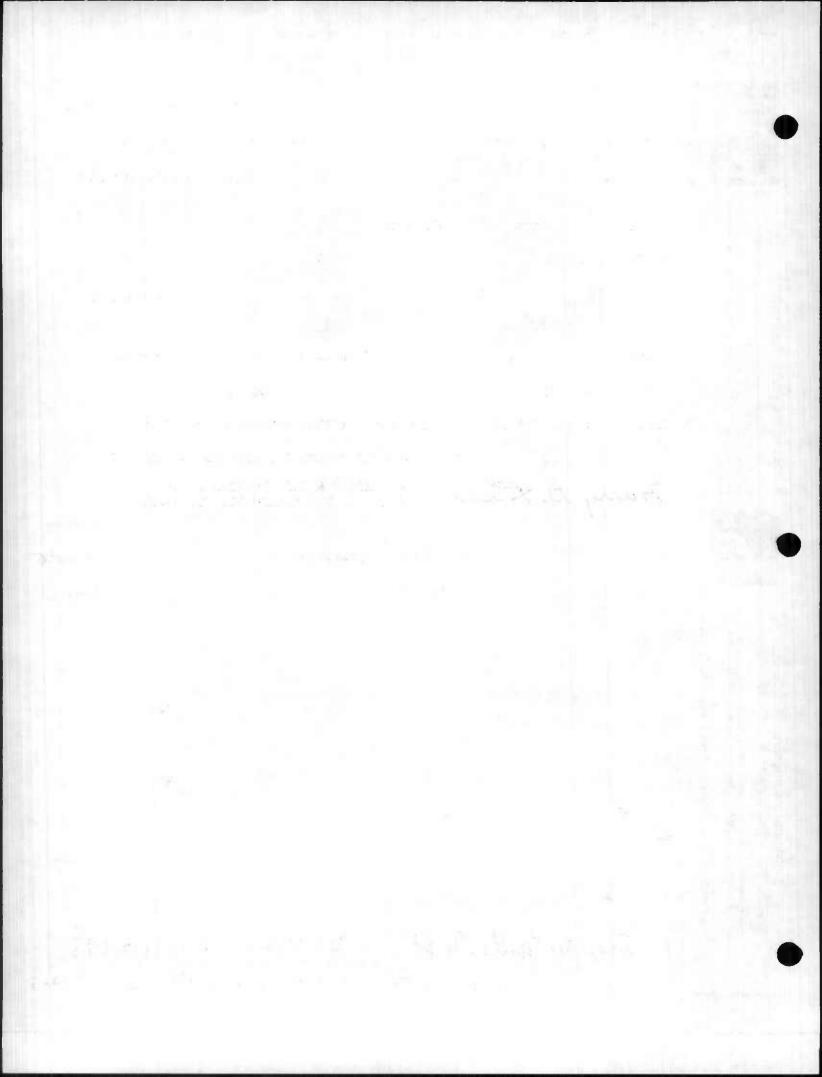
State of Maryland / Department of Health and Mental Hygiene 8 02 139

_						C	ertifica	ate of	Death	F	leg. No.	U	133	
Physician		1. Decedent's Name (F	First, Middle, La	st)						2. Date of Dea Month		Year	3. Time of Death	
/Medical		GEORGE		PETER			S	AMM		JANUARY	9 ^{Dey} 199	8	10:30 A	
Examiner	r	4a. Facility Name (If no	t institution, giv	e street end nu	m <i>ber)</i>				4b. City, Town, or	ocation of Death	4c. County	of Deeth		
	4	CHESAPEAKI					T WY		ARNOLD		AA			
Funeral		5. Social Security Numl		Sex I□M 2□F		rs. last birthda Yrs.	Month	er 1 Year a Days		(Month, Day	Year)	Counti		
Director	-	216/09/51! Usual Residence of De		XX	92	113.				5/23/1	.905	MARY	LAND	
8 m	- 1-		b. County		10c.	City, Town or	Location					10	d. Inside City Limits	
r 28a-f show	5	MD	AA			ARNOLD							1 ☐ Yes & ☐ No	
or 28a-f si	3	10e. Street end Numbe	r					ip Code			0g. Citizen of	What Count	4141	
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	<u> </u>	11. Marital Status		12. Wes Deci	edent Ever i	n U,S. 13	3. Was Dec		Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No-		a - America	n Indian,	
a and		1 Never Married	2 Married	Armed Fo	20 No					o Rican, etc.)		ck, White, e		
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ygiene. Ner than "natural", nt, the Medical Ex	2		Decedent's Ed			16a. De	cedent's Us	ual Occu	pation	tein a	16b. Kind of B	usiness/Indu	ustry	
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d out		17. Fether's Name (Firs							18. Mother's Nan	ne (First, Middle,	Maiden Sumen	10)		
nd Mental marked o umatic eve	2	CHARLES	3	R.	5	SAMM			AUG	USTA	LUCI	KHARDI	-	
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int: If ite	1			Removal from		b. Placa of Dis cemetery, c	rematory o	ame of other pla	ace)	Date	20c. Location	City or Tow	m, State	
Department or Important: If i any injury or once.	-	4 Donaton 5	Other (Specif	1		LEN HA	VEN M	EMOR	IAL PARK	1/13/98	GLEN BU	JRNIE,	MD	
Departm Importar any injur		21. Signature d Furiers	al Service Line	1000			22. Name	and Addr	ess of Facility SI	NGLETON	FUNERAL	HOME	,	
205 20	any ii	20a. Method of Disposition XXBurial 2 Cremetion 3 Removal from State 4 Donafor 5 Other (Specify) 21. Signature of Funeral Service Communities 20b. Place of Disposition (Name of cemetery, crematory or other place) 21. Signature of Funeral Service Communities 22c. Location - 20c. Lo												. 21061
hysician /Medical Examiner ம்		Immediate Cause (Fina disease or condition resulting in death)	al	· KE	SP1	RATO o (or as a cons	RY sequenca o	i):	FAILU	RB_	KY NU	12.004	Onset and Death Week Year	
hysician and the buriel-transit dical Examiner		Sequentially list conditi if any, leading to imme	ons, diate	b. 071		o (or as a cons				(0,0)			δ μς.	
physician ts the burie edical E		Sequentially list conditi if any, leading to imme- cause. Enter Underlyin Ceuse (Disease or injui that initiated events resulting in death) Last	gy K	C	Due to	o (or es a cons	equence of):	<u> </u>					
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the e		Part ii. Other significan	t conditions c	ontributing to de	eath but not	resulting in the	underlying	cause gi	iven in Part I.	23b. Did to	bacco uaa co	ntribute to	the causa of death	
tate hes been signed by the ettendir page 2 should be deteched for use completed by Physician/N		(provery	Br	ters /	Inseas	2				1□ Y	es 2 No	3 🗆 Probe	ably 40 Unknow	
be of y	1	0	, - 0											
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hes b												of de	pletion of cause eath?	
page page										1 □ Y	es 2000	1 🗆	Yes 2□ No	
s certificate director, pag		25. Was case referred to examiner?	to medical						26. Place of Dee	th (Check only or	е)			
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or: A the f		2 Accident	investigation Could not be				М		Yes 2 No					
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or the omple		onej		and man	ner stated.									
× 00		29b. Signature and title		1 1		1	_ 2	ec. Licen:	se number	2	9d. Date signe	a (Month, D	ay, Year)	
			meeM'	Hae	udly	Doct	V	D	21684		7-7	-10		
	;	30. Name and eddress	of person who	completed caus	e of death (I	tem 23a) (Typ	e, Print)		21684 PASA01	ENA 1	10 211	22		
		CV-CYRI	AE-14.1	810	DY R	ITCHER	- 05	VI,	MATICAN	1	~ ~ II			
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					C	ertifica	ate of	Death		Reg. No.	02	2140		
Physician		Decedent's Neme (First, Middle, La							2. Dete of I	Dev	Yeer	3. Time of De		
/Medical	1	BESSIE L.		_						11 1998		0239		
Examiner	١.	4e. Fecility Neme (If not institution, giv						4b. City, Town,	or Location of De	eth 4c. Cour	ty of Deeth			
	_	ANNE ARUNDEL MEDIC			for a b last at-) If the	er 1 Year	ANNAPOI			ARUNI			
Funeral Director		5. Social Security Number 6. S 216-22-2836 Usual Residence of Decedent	M 25 F	Age (in yrs	. last birthda Yrs.	Month			lin. (Month, I	9irth Dey, <i>Year)</i> 16 1915		lace (State or Fo try) AND		
show		10a. State 10b. County									1	0d. Inside City L		
or 28a-f st		MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street end Number 10f. Zip Code 10g. Citizen of W									Whet Coun	1 XYes 2 try?		
		208 BOWIE AVENUE	2				2140	1			US			
Examiner must		11. Maritel Status 1 Never Merrled 2 Marrled 3 Widowed 4 Divorced	12. Wes Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	XNo	J,S. 13		edent of hecify Cub		(Specify Yes or It erto Ricen, etc.)		ace - Americ ack, White, ify: BLAC	etc.		
"natural", of cal Eu		15. Decedent's Ed (Specify only highest gre	ducetion		16e. Dec	edent's Us	uel Occup	etion	uadina	16b. Kind of	Business/Inc	lustry		
r than		Elementary/Secondery (0-12)				(Give kind of work done during most of work life. DO NOT use retired) HOMEMAKER				OWN HOME				
d other event, the Be Co	2	17. Father's Neme (First, Middle, Last,						18. Mother's N	lame (First, Midd		Ma make at a			
marked marked imatic e	2	THOMAS WALLACE 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Ru							AGGIE					
Ith au 27 Is r trau		ATRICIA SIMMS (DA							APOLIS,			0000)		
Department of Health and Mental Hyg Important: if Item 27 Is marked other any fnjury or other traumatic event, once. To Be C	-	20a. Method of Disposition 1 Buriel 2 Cremetion 3		20b.	Plece of Dis	position (A	eme of other ple	ce)	Dete	20c. Location	- Clty or To			
tant		4 ☐ Donetion 5 ☐ Other (Specifi	*	MI					1/16/98	1	N, MD.			
Depa Impor		21. Signeture of Funerel Service Licer		sa	V	22. Name VM. RI 321 WI	end Addre EESE EST S	ss of Facility & SONS T. ANNA	MORTUARY POLIS, M	, P.A.	1			
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neral neral		27. Manner of Death	28e. Dete of In (Month, L	jury Dev Year)	28b. Time Injury		28c. Injur Wor	y et k?	28d. Describe	how Injury occi	ırred			
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within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To		3 Sulcide 6 Could not be determined	28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)						28f. Location City or T	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death **Physician** Month Swyder Charlotte Lucille 740 10 /Medical 4a. Fecility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 204 SlepBurnie TIGHLAND If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 09-20-1945 if Under 1 Year 5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthday) 9. Birthpiaca (State or Foraign **Funeral** 1□M 2 F Deys 212-42-4374 52 Yrs. Director MARYLAND Usual Residence of Decedan the Maryland 10e. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2 No Director ANNE ARUNDEL MARYLAND GLEN BURNIE 10e. Street and Number 10f. Zip Coda 10g, Citizan of What Country? ò items 23a 338 HIGHLAND DRIVE APT. 204 21061 deeth Funeral U.S.A. 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ☐ No tf Yas, Give Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, atc. 72 hours efter 1 □ Navar Married 2 □ Married ò 1 Yas 2 No Specify: Àq 3 ☐ Widowed 4 ☒ Divorced Specify: WHITE "natural". Completed 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Spacify only highast grade complated) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumeric. Elementery/Secondery (0-12) College (1-4or 5+) 12 YEARS YEARS LEGAL LAW FIRM 17. Fether's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumema) CHARLES JOHN GEIZER DOROTHY MAY KINNON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rurel Routa Number, City or Town, Stete, Zip Code) PAULETTE L. WHITEHAIR (FRIEND) 3508 BUCKBOARD LANE BALTIMORE, MARYLAND 21220 20b. Placa of Disposition (Nama of cematery, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH CEM. 1-16-98 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility THE SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MARYLAND 21061 nclications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, y one cause on each line. **Physician** /Medical Immediata Causa (Finel UNK disease or condition resulting in death) Examiner Rulmonary Disease buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, laading to immediata causa. Entar Undarlying Ceusa (Disaase or injury that initiated avents rasulting in daath) Last and physician Physician/Medical the Due to (or as a consequanca of): attending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? à 1 Yes 2□ No 3 ☐ Probably 4 ☐ Unknown signed b Be Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? peen pege 2 s 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificete 25. Was case refarred to medical 26. Place of Death (Chack only ona) Othar: 4 Nursing Homa 5 Rasidanca 8 Othar (Spacify) 10 1XYes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of Daath 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: 5 Panding Invastigation 1 Natural 1 Yas 2 No 2 Accident 3 ☐ Suicida 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Placa of Injury - At homa, farm, straet, factory, office building, atc. (Spacify) 4 Homicide

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Baltimore, Maryland 21215-0020

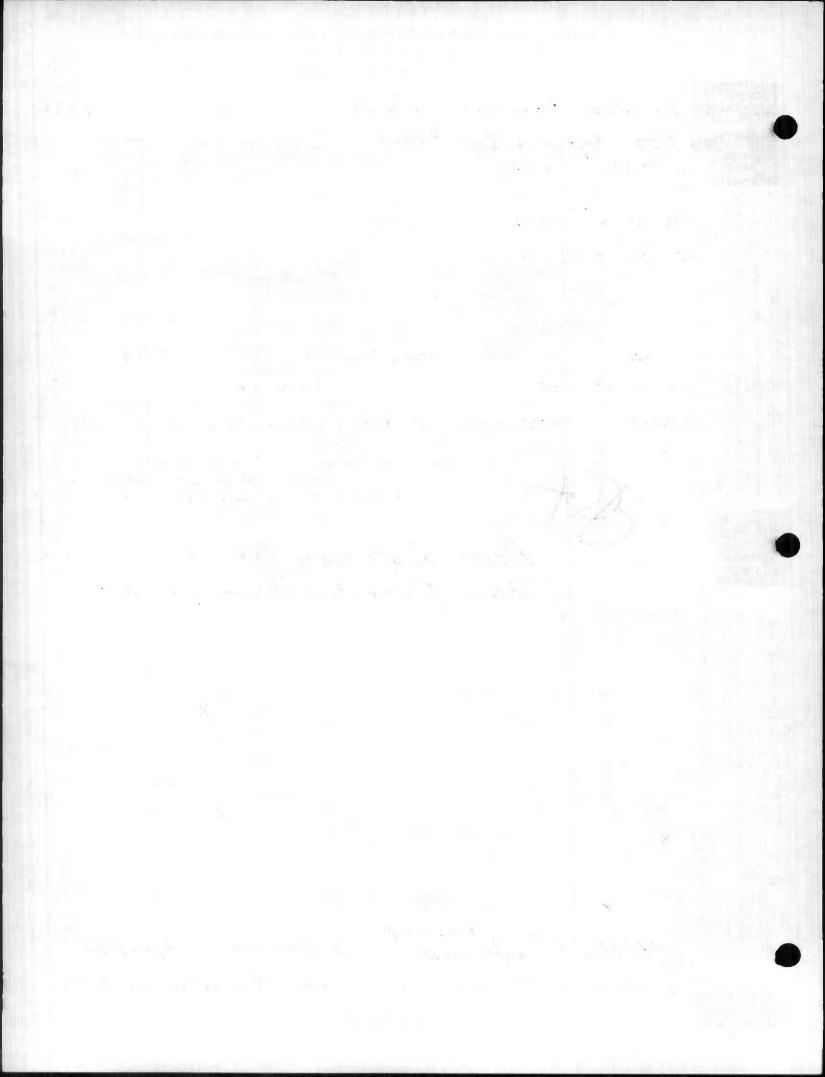
29a, Cartifian t 🔲 Certifying Physician: To tha best of my knowledga, daath occurred at the tima, data and placa, and dua to tha cause(s) end manner es steted. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, deta and piece, and due to the causa(s) and manner stated. 29b. Signature end titla of cartifia 29c. Licansa numbar 29d. Deta signed (Month, Day, Year) eputy

eted causa of death (Item 23e) (Type, Print)

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State Registrar

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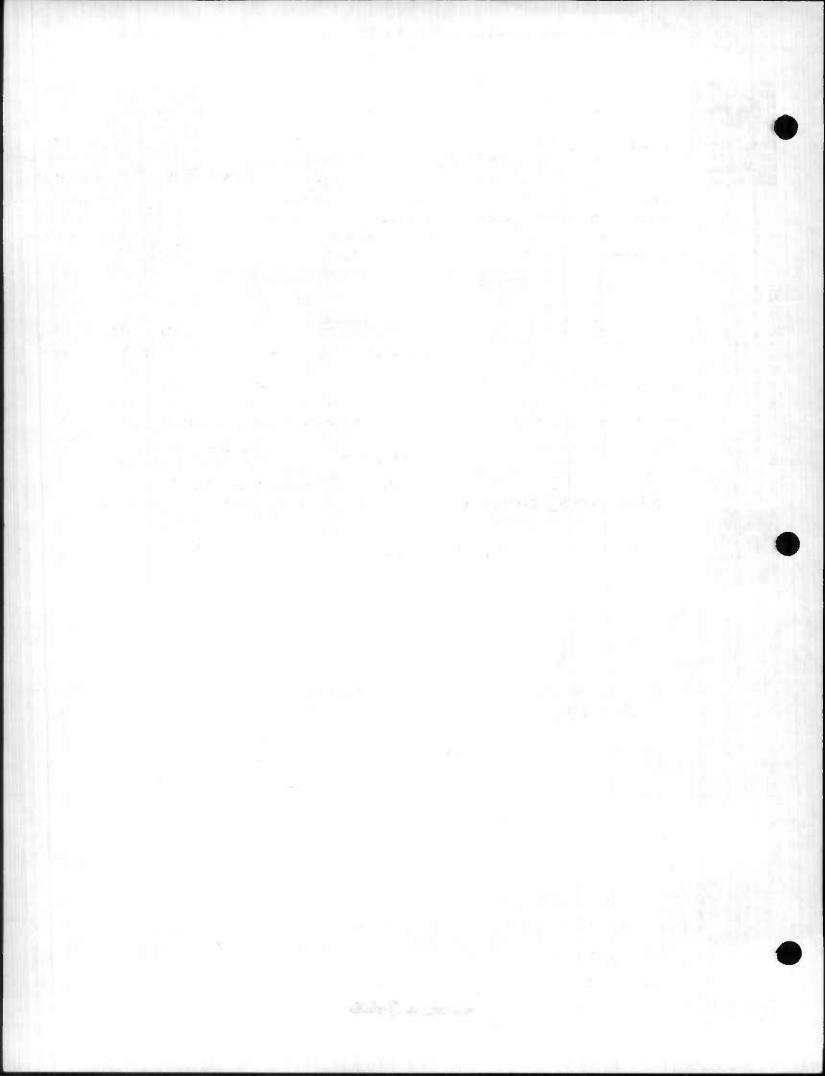
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Dey **Physician** JERRY CLAYTON STEELE 1998 JAN 4 5:32 PM /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 8. Date of Birth (Month, Day, Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** Deys Hours 1 M 2□ F 230-64-9878 Virginia 49 Yrs Director Oct. 8, 1948 Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, it a Madical Examinat must be notified at 10d. Inside City Limits 1 Yes MNo Directo Spotsylvania VA Spotsylvania 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 10707 Maple Ridge Drive permit. Peges 1 and 2 should be filed within 72 hours after death 1 Department of Health end Mentel Hygiene. Important: If item 27 is merked other than "natural", or itema 23a, any Injury or other traumatic event, the Madical Examener research. 22553 United States of America Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1XX es 2 □ No If Yes, Give Year or Detes: 1 Never Merried 20XMarried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorcad White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Officer U.S. Marine Corp 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Clayton Steele Beulah Hooker 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Linda M. Steele - Wife 10707 Maple Ridge Drive Spotsylvania, VA 22553 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete XXBurial 2 Cremetion 3 Removel from State 1-8-98 4 ☐ Donetion 5 ☐ Other (Specify) Alleghany Memorial Park Covington, VA 21. Signeture of Funeral Service Licansee 22. Name end Address of Fecility Arritt Funeral Home, Inc. 1102 S. Highland Avenue Covington, Virginia 23a. Party. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shall, or heart failure. List only one cause on each line. Approximate intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical METHICILLIN RESISTENT STAPHYLOCOCCUS AUREUS SEPTICEMIA Examiner Due to (or es e consequence of) Examiner HIV INFECTION physician end s the buriel-transit The law requires thet the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of). Box 68760, ACQUIRED IMMUNE DEFICIENCY SYNDROME Physician/Medicai Due to (or es e consequence of) for use es ed by the e Pert II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t þ been si 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? Pes page 2 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: director 25. Wes case referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funerel 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Neturel 2 Accident 5 Pending death. 1 Yes 2 No investigation ofter death

Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 🛣 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner es steted. Medical (Check only one) 2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) ohn T. Schull, M.D 18201 (WV) 051 38 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 JOHN T SCHINDLER, LT, MC, U 31. Dete filed (Month, Day, Year) 32. Register's Sign State JAN 1 6 1998 Registrar

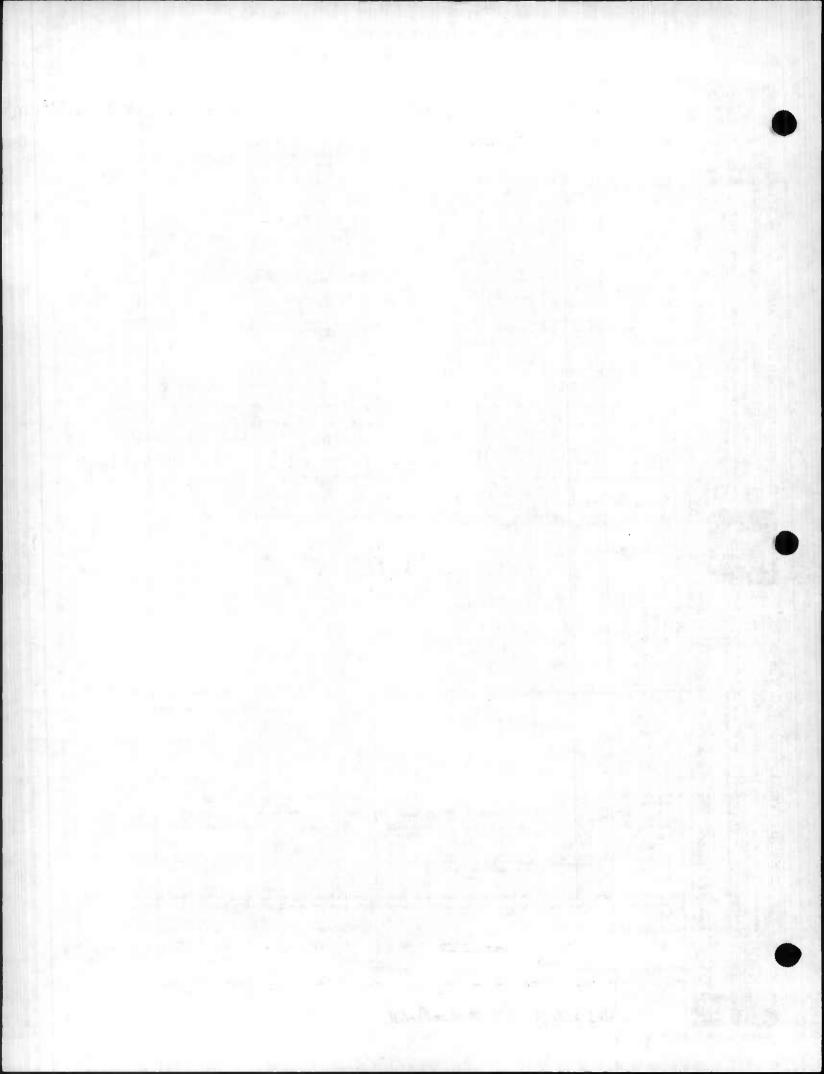
State of Maryland / Department of Health and Mental Hygiene 8 02 14 3

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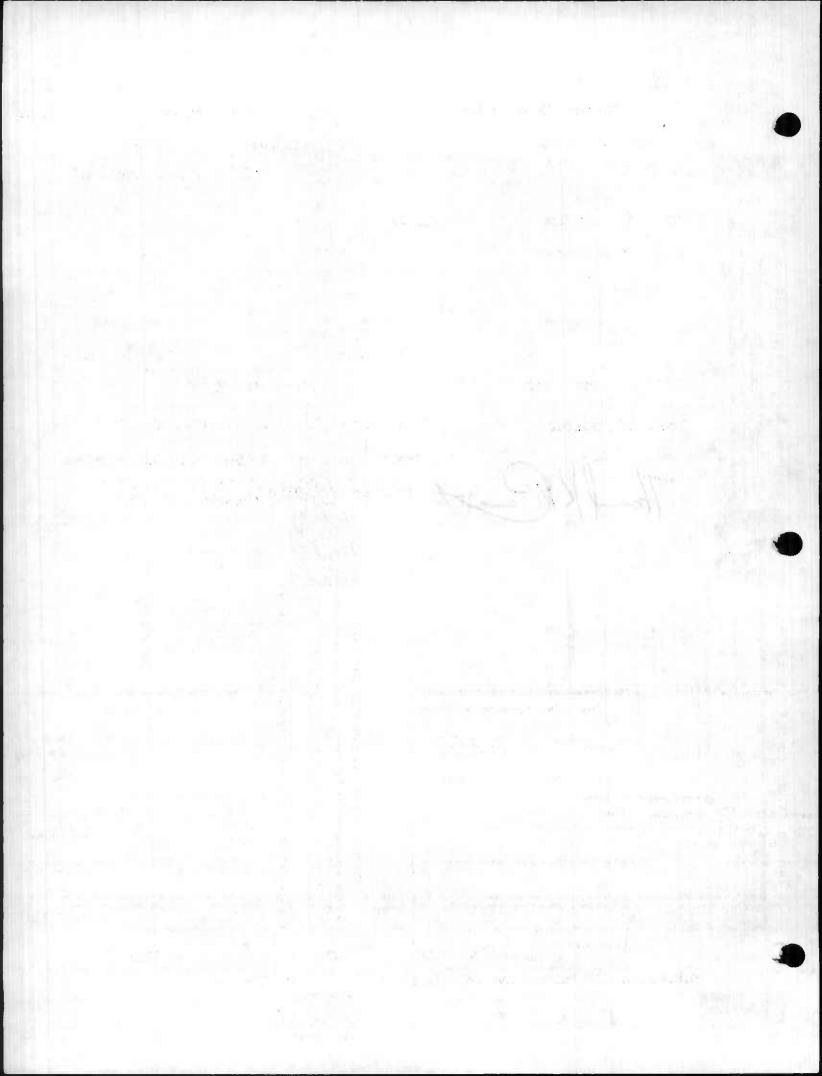
State of Maryland / Department of Health and Mental Hygiene

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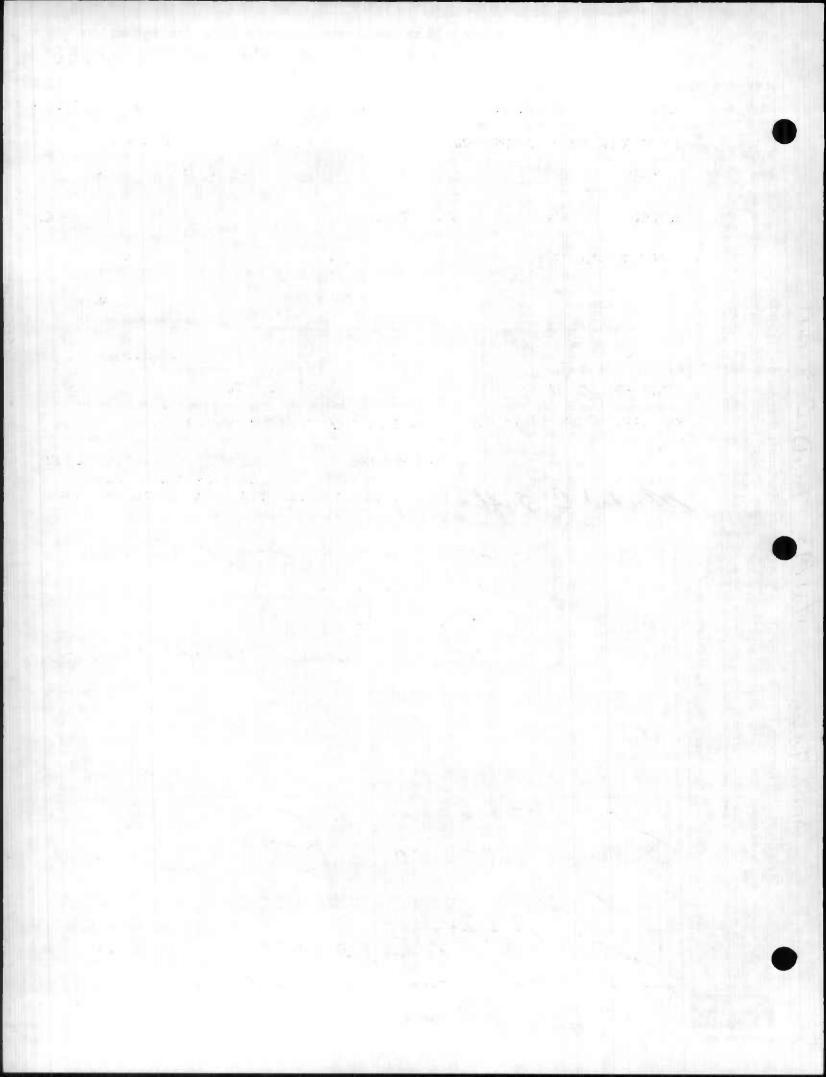
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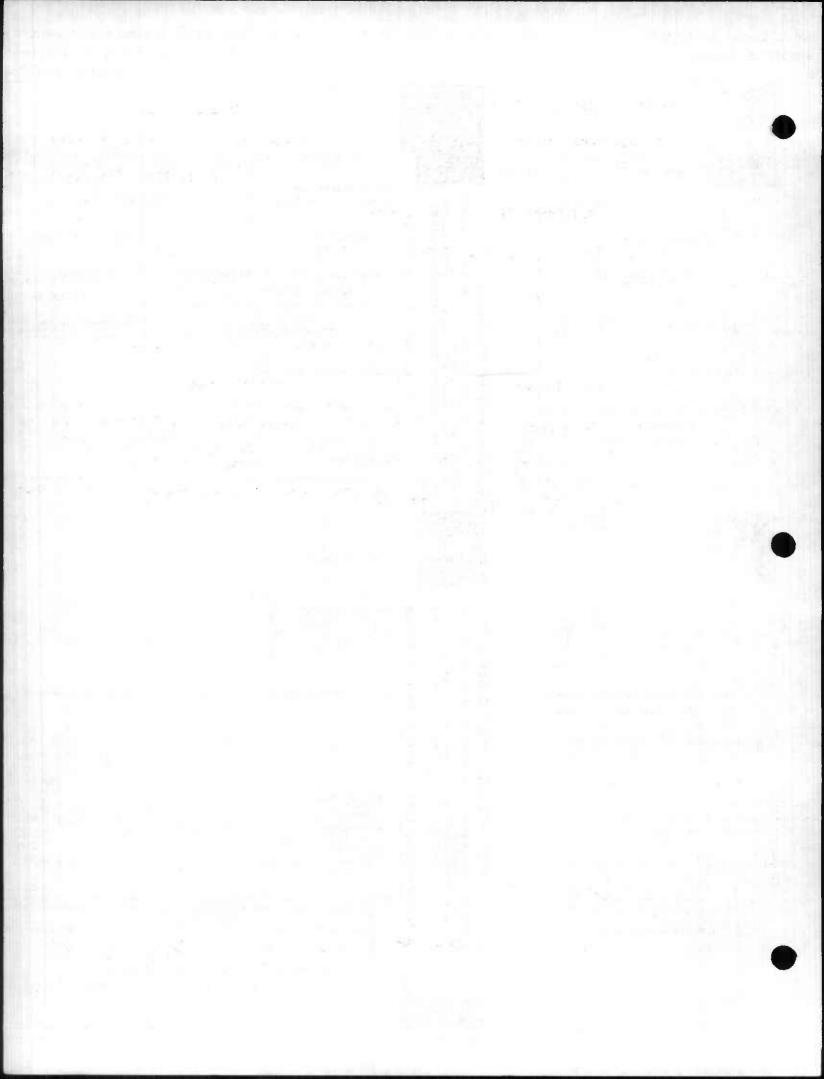
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4		PARLOS	W. PATAL	1164	TUB	01	8426		1-12	-98	>
		30 Nume and address of person 402 6. Ph	who completed cause of de	ath (Item 23a)	(Type, Print)	AL.	T.MO.	3/225	-		June 1
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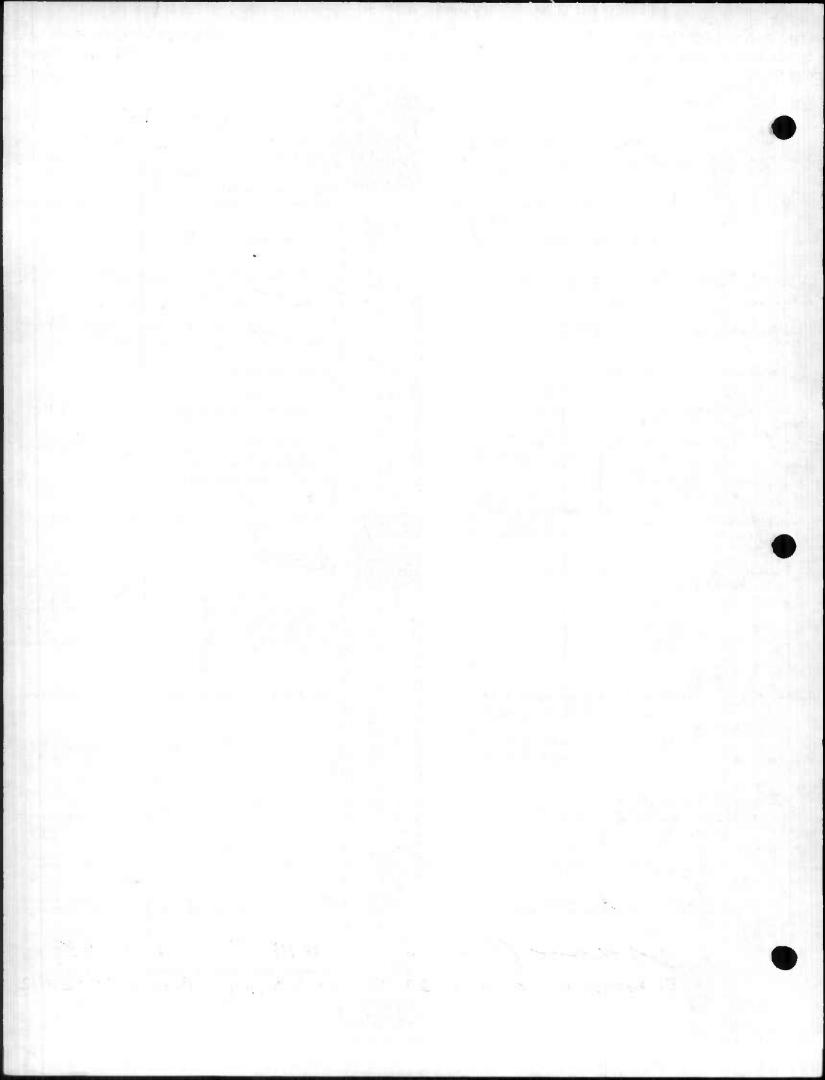
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THE RESIDENCE OF THE PARTY OF T	Completed	15. Decedant's Edu (Specify only highast grad	rcation fa complatad) College (1-4or 5+)	(Give	tant's Usual Occup kind of work done DO NOT use retire maker	pation during most of work d)	ing	16b. Kind of Busin	nass/industry
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other t	-	Daniel F. Thomas/s		b. Place of Dispos	sition (Nama of		Dete	20c. Location - Cit	ty or Town, Steta
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any injury ance.	J	21 Stinature of uneral Service Licens	00		. Nama and Addra				Funeral
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	ai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Dua	to (or as a consequ	uance of):		-		
8 1	olbe	that initiated events resulting in death) Last	Due t	o (or as a consequ	uence of):				1
	9								
	Sici	Pert II. Other significant conditions cor	ntributing to death but not	resuiting in the un	ndarlying causa giv	ven in Part I.	23b. Dld	lobacco use contri	bute to the cause of
e est uni paunetan an	by Phy	Pert II. Other significant conditions con		resuiting In tha ur	ndarlying causa giv	ven in Part I.			bute to the cause of
e est uni paunetan an	p			resuiting In tha ur	ndarlying causa giv	ven in Part I.	1 🗆	Yes 2 D/No 3	
e earn ou pause se	Completed by	hyperlenes		resuiting In tha ur	ndarlying causa giv	ven in Part I.	1 🗆	an autopsy med?	Probably 4 Ur 24b. Were autopsy fin availebla prior to completion of cau
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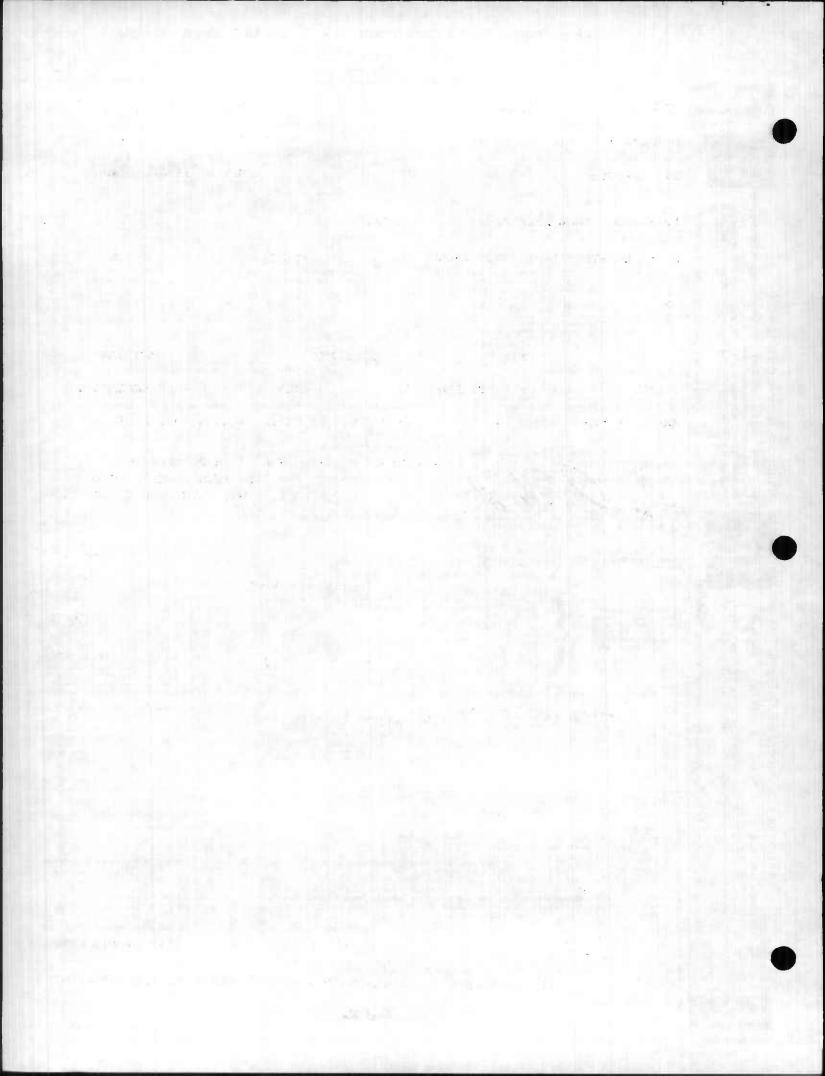
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

Physic	ian	Decedent's Nama (First, Middle Nancy Ga	e, Last) allishaw	Weh	ster			2. Dete of D Month	Day	Yaer 0910 AM	
/Medi		4a. Facility Name (If not Institution			ocer.		4b. City, Town, or	01	11 199 th 4c. County	90	
Exami	ner	Chesapeake Heal					Arnold	2002101101		Arundel	
- uneral director		5. Social Sacurity Number 564 22 6441		ga (In <i>yrs. I</i> e 74		If Undar 1 Yaar Months Days	If Under 24 Hrs Hours Min	8. Data of B	irth 9/18/23	9. Birthplece (Stete or Form Country) Massachusett	
28a-f ahow notified at	٥٢	Usuel Residence of Decedent 10e. Stete 10b. County MD Anne	Arundel		Town or Local					10d. Inside City Lin 1 ☑ Yes 2 □	
3a or 28a- at be notifi	Funeral Director	10e. Street and Number PO BOX 3481				10f. Zip Code 21403			10g. Citizen of W USA	/het Country?	
Deperment of reein and Mentel hygiene. Important; or items 23s or 28s-f show important; if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinet must be notified at 2008.	b	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes Give 4	?		s Decedent of I as, specify Cub	dispenic Origin? (an, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	o- 14. Raca Bled Specify:	- Amarican Indien, k, White, etc. White	
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rked tic ev	To B	John O. Gallis	shaw				Elean	or Brow	n		
27 Is ma trauma		19a. Informent's Name/Reletions Wilbur Webster					end Number or F		ber, City or Town, 3	Stete, Zip Code)	
ant of Heel it: If Item 2 y or other		20e. Method of Disposition 1 ☐ Burial 2 ☑ Cramation 4 ☐ Donetion 5 ☐ Other (S	3 □Removei from State	ca	eca of Dispositi matary, cremat		ce)	Dete 01/12	20c. Location - (City or Town, Stete	
Depertm Importar any Injur		21. Signature of Funeral Service		4	22. N Ad	iame end Addre	ess of Fecility	Cremati	on Servi	ces	
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attending for use a	lan		d								
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has been sign ge 2 should be	Completed by								s en eutopsy formed?	24b. Were autopsy findin available prior to completion of cause of death?	
page page	Co							1 🗆	Yes 2000	1 ☐ Yes 2 ☐ No	
is certificate has director, page 2	Be	25. Was case referred to medica examiner?	Hoepital:			OH		eath (Check only			
£ .≅	atlon: To	1 Inpatient 2 EH/Outpatient 3 DOA 4 MANUSIE							g Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 28d. Describe how injury occurred		
within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	Medical Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Piece of Injury - At home, ferm, street, fectory, offica building, atc. (Specify)							(Street end Number own, State)	er or Rural Route Number,	
Y fi	dical	29e. Certifier (Check only one) Certifyin 2 Medical	g Physician: To the best Examiner: On the basis of end menner si	f exeminetic	iedge, deeth oo on end/or invas	ccurred et the ti tigation, in my o	me, dete end pied opinion, deeth occ	e, end due to the curred et the time	e cause(s) end mei e, dete end piace, e	nner es steted. end due to the cause(s)	
P. F.	A e	29b. Signature end titla of certifie		sa number		-	(Month, Dey, Year)				
within 24 To the Fu	-	30. Name and address of person REBECCA 21. Date find (Month, Pay York)	~6	Le	-		04195			11-98	



State of Maryland / Department of Health and Mental Hygiene

		C	ertificate of	Death	Я	leg. No.	0214	9
1. Decedent's Name (First, Middle		1.011114	N-III	11-11-11	2. Dete of Dea Month	th Day	Year 3. Time	e of Death
GERTRUDE	WELCH		100		JANUARY		998 5:	45 AM
4a Facility Name (If not institution	n, give street end number)			4b. City, Town, or L		4c. County of	of Death	
HARBOR HOSPITA	al center			BALTIM			/A	
5. Social Security Number 226-44-9053	6. Sex 7. Age	(In yrs. lest birthdo	Months Davs		8. Date of Birth (Month, Dey MAY 5,	, Yeer) 1918	9. Birthplace (Ste Country) GERMANY	te or Foreign
Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside	a City Limits
	E ARUNDEL	т.	ASADENA					res 2 No
MARYLAND ANNI 10e. Street and Number	L AKONDED		10f. Zip Code			log. Citizen of W		Λ
0400 ==================================	ד אאוב אוסיים	500		21122			S.A.	
8108 FOX BERRY 11. Marital Status 1 □ Never Married 2 □ Marri	12. Wes Decedent E		Was Decedent of If Yes, specify Cut		pecify Yes or No-		- American Indian	1,
₩ Widowed 4 Divorced	If Yes Give		If Yes, specify Cult 1□ Yes 2□XNo		Rican, etc.)	Specify:	k, White, etc. WHITE	
15. Decedent (Specify only highes Elementery/Secondary (0-12) 12	t's Education	16a. De	cedent's Usual Occu	petion	kina	16b. Kind of Bu	siness/industry	
(Specify only highes Elementery/Secondary (0-12)	College (1-4or 5-	·) (G	ive kind of work done B. DO NOT use retire	9d)				
12	N/A		HOMEMAK	_			HOME	
17. Fether's Name (First, Middle,				18. Mother's Nam	ne (First, Middle,			
JOHANN		TENMEIER		ANNA			RSCHBAUN	
19e. Informant's Name/Relations		1	ailing Address (Stree					
KAREN BRANAN	(NIECE)		MATCHPOII sposition (Neme of	NT DRIVE,	,			
20a. Method of Disposition 1 🛣 Burial 2 □ Cremetion	3 Removal from State	cametery, o	cremetory or other ple	eca)	Date	20c. Location -	City or Town, State	,
4 Domation 5 Other (S		MEADOWR	IDGE MEMO					
21. Signature of Funeral Service	Licensee L		22. Name and Addr 1 SECOND	ress of Facility SII				1061
23a Part Enter the disease, or	complications that caused only one ceuse on each line	ne dimin. Do not					Approxi	mate
or heart failure. List	only one ceuse on each lin-	9.						Between nd Deeth
Immediate Ceuse (Final	T . 1 . 1	0	7				20	ha
disease or condition resulting in deeth)	a. End sta	ge Keval						+
<u> </u>	Insulin	depende	nt Diabet	es Mellitus	>		20	The
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Hypent	ension					1 Qe	yr+
Cause (Disease or injury that initiated events resulting in death) Last	C. C	ue to (or as a con-	sequenca of):					0
Š į	gang	eyene	Left	del			IW	ule
	d. 0		4	0				
Pert II. Other significant condition	ns contributing to death bu	not resulting in th	e underlying cause g	iven in Part I.	23b. Did t	obacco use con	tributa to the cau	se of death?
	offine H	en	Laile	ve .	101	res 2E No	3 □ Probably	4 🗆 Unknown
8	()	(J			TAR COLUMN		f- "
					24a. Was a	an autopsy med?	24b. Were autop available pr completion	rior to
<u> </u>					1		of death?	J1 500000
5					1 🗆 Y	es 20 No	1 ☐ Yes	214No
25. Wes case referred to medical exeminer?				26. Place of Dee	th (Check only o	ne)		
1 ☐ Yes 2 ☑ No	Hospital:		tient 3 DOA		ome 5 Resid			
	g 28a. Dete of Injury (Month, Dey	Year) 28b. Tim	y Wo	ury at ork?	28d. Describe h	ow injury occurr	ed	
27. Manner of Deeth 1 Staturel 2 Accident investig 3 Suicide 4 Homicide 5 Pendin investig 6 Could r determ	gation	A11		Yes 2 No	006 Least's a 46	Street and At	or or Dural Court	Mannhaa
4 Homicide determ		ry - At nome, farm, (Specify)	street, factory, office		28f. Location (S City or Tow		er or Rurel Route I	vaniber,
29a. Certifier 1 Certifyin (Check only one)	g Phyaician: To the best of Examiner: On the basis of end menner stat	examination end/o	eeth occurred et the t r Investigation, in my	time, dete and placa opinion, death occur	, and due to the or rred at the time, or	ceuse(s) end ma date and placa, e	nner as stated. and due to the cau	se(s)
29b. Signeture and little of certifier			29c. Licer	nse number		29d. Date signed	(Month, Dey, Yes	ar)
				441614-A			RY 13,199	
Sphot	and the same of th		1 1 4 3 1 24					_
20 Name and officers of account	who completed enuise of de	ath (Itam 32a) /T		-,				
30. Name and address of person SHIV KUMAR PATIL,			pe, Print)			BALTIMORE	= MD 2122	<i>5</i> .

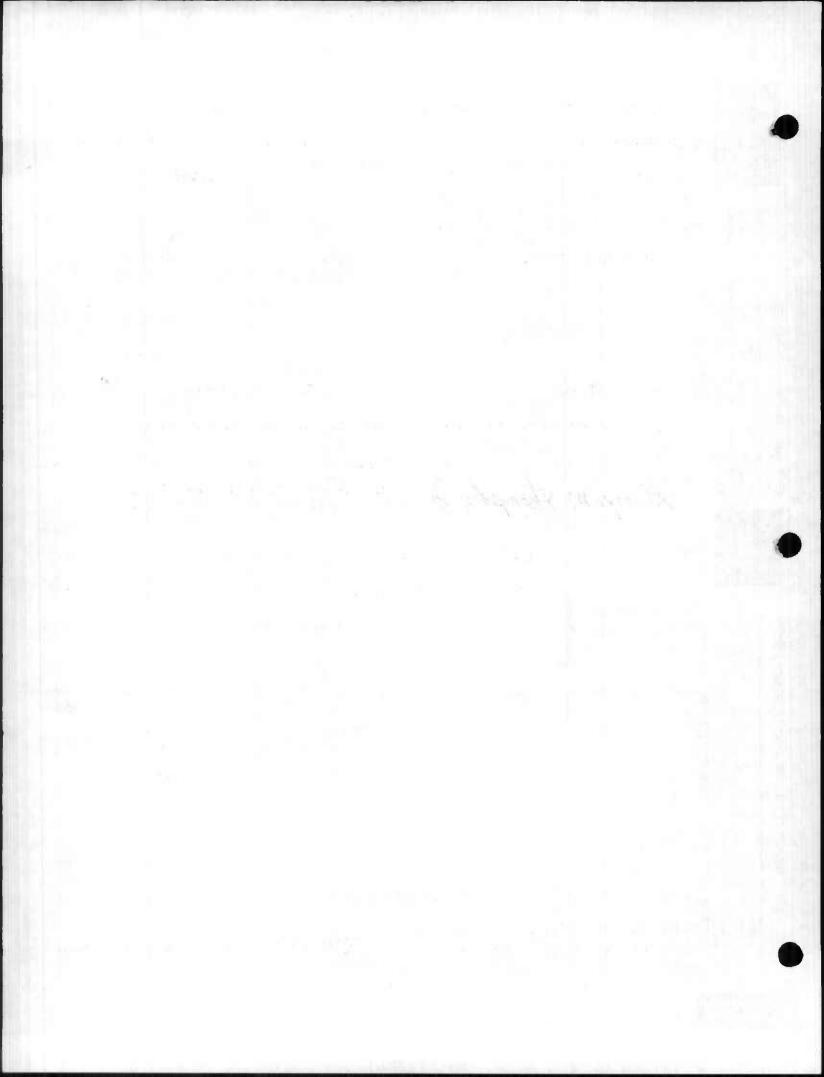


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

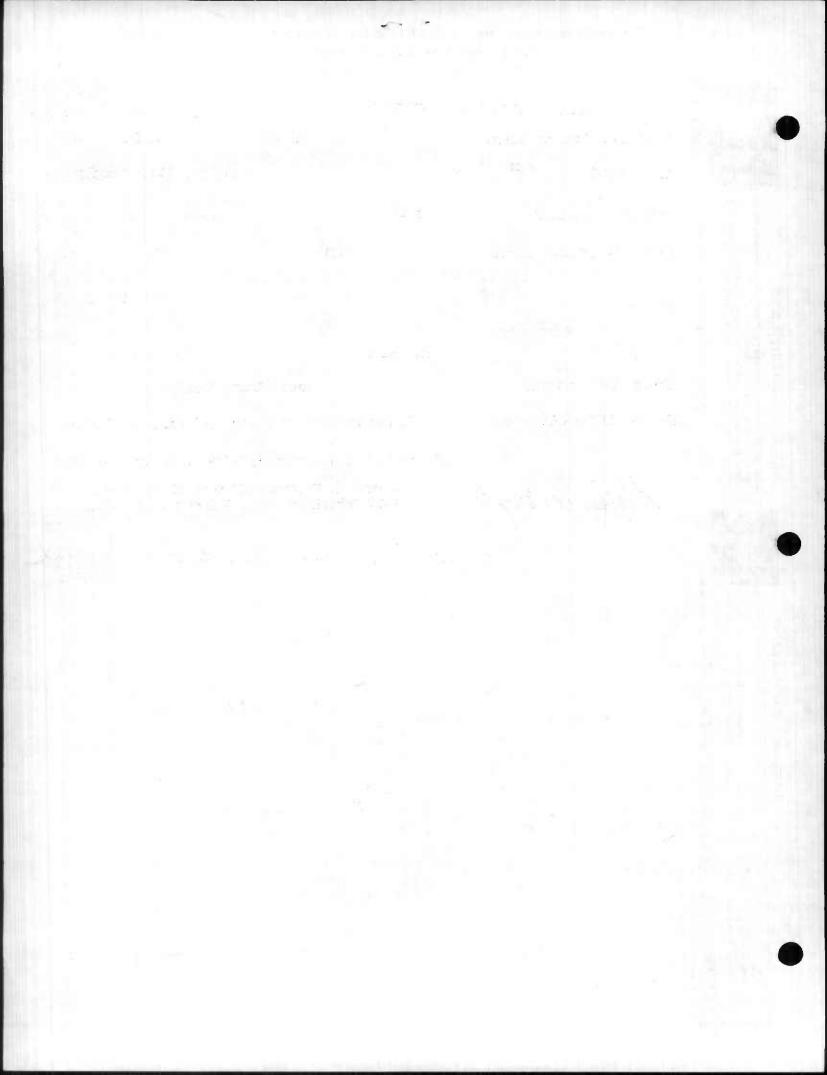
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/Medic		ROSALEE H		BURY				MAL	13	1998	5 54	
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<u> </u>		University of Ma					Baltimore			timore		
neral ector			Sex 1 □ M 2 X F 7. Age (In y	rs. last birthda Yrs.	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 08 / 19	ay, Yeer)	9. Birthp Coun	lace (Stete or Fore try) MD	
notified at		10a. State 10b. County	10c.	City, Town or	Location					1	0d. Inside City Lim	
	Director	MD Harfor	rd I	Bel Air	•						1 ☐ Yes 🎾 N	
9 10	Sire.	10e. Street end Number			10f. Zip	Code			10g. Citizen o	f Whet Coun	itry?	
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	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U,S. 13	3. Was Deced	lent of Hi	ispenic Origin? (Sp in, Mexican, Puerto	pecify Yes or No Rican, etc.)	o- 14. R	ace - Americ lack, White,		
Egg	by	1 Never Married	1 Yes 2 No If Yes, Give Year or Dates:		1□ Yes 2		Specify:		Spec			
dica	Completed	15. Decedent's E (Specify only highest gi	Education rede completed)	(Gi	cedent's Usua ve kind of wor	k done d	during most of worl	king	16b. Kind of	Business/Ind	dustry	
The Me	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life	. DO NOT us	e retired)					
f.	ပ္ပ	17. Fether's Name (First, Middle, Las	4		Tead	cher	18. Mother's Nam	o (First Middle		nool		
	Be	Edward Hollahan								ame)		
matic	2	19e. Informent's Name/Relationship		10b Ma	ilina Addrese	(Street	Sue Ka			m Ctata Zin	Code	
trau		Grayson C. Wood									C00e)	
other		20a. Method of Disposition		b. Place of Dis	position (Nam	ne of		Date Date	20c. Location		wn. Stete	
yor		1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donetion 5 ☐ Other (Special			remetory or of		,	1/17/00		,		
Injur		21. Signature of Funeral Service Lice	111	lt. Erir	22. Name and			1/1//98	Havre	de Gi	race, MD	
any ir		Han In	House Land		Mitche	II-Si	mith Fun					
		23a. Pert1. Enter the disease, or con	nnlications that coused the d	eath Do not a	23 S.	Was	hington	St., Ha	vre de	Grac		
cian		shock, or heert failure. List only	y one cause on each line.	0000		o o. ay	g, out of our las	or respiretory e	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Approximete Intervel Between Onset end Deet	
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State of Maryland / Department of Health and Mental Hygiene 8 02 15 1

					Cer	tificate of	Death		Reg. No.	UZ	
Physicia	an	1. Decedent's Neme (First, Middle,						2. Dete of De Month	eeth Dey	Yeer	3. Time of Death
/Medica		GLADY		TH	WINSK	OWSKI	4 O' T		5 199		7:20 AN
Examine	er	4e. Fecility Neme (If not institution, 10 Meadow Spri					4b. City, Town, or Bel Air			ford	
Funeral Director		5. Sociel Security Number 212–76–3096	. Sex 7. Age	95	st birthday) Yrs.	If Under 1 Yea Months Dey		8. Date of Bir (Month, Da July 1	th Year) 1902	9. Birthple Country Mary	ce (State or Foreign 7 Land
2		Usuel Residence of Decedent 10e. Stete 10b. County		10c City	Town or Lo	ontion				10.	4 1-14-02-11-2-
Sa-f short	Director	Maryland Harf	ord		el Ai					100	1. inside City Limits 1 ☐ Yes 2 🖔 No
23a or 2	al Dire	10e. Street end Number 10 Meadow Sprin	ngs Drive			10f. Zip Code 210			10g. Citizen of USA	Whet Country	y?
9 🗎	by Funeral	11. Maritei Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Decedent of Yes, specify Cu	Hispenic Origin? (S ban, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)		ce - Americar ck, White, et y: Whit	c.
marked other than "natural", imatic event, the Medical Exa	Completed	15. Decedent's	Education arede completed)		16e. Deced	lent's Usuel Occi	upation e during most of wor ed)	rkina	16b. Kind of B	usiness/indu	stry
	ID I	Elementary/Secondary (0-12)	College (1-4or 5-	+)			9d)	9			
If item 27 is marked other than or other traumatic event, the M		17. Father's Name (First, Middle, Le	st)	Į.	Homem	aker	18. Mother's Nar	na (Firet Middle	Own Ho		
atic eve	o Be	Edgar (UK) Ham						Laura Ha		110)	
meri	To	19e. Informent's Name/Reletionshi			19b. Mailin	a Address (Stree	et end Number or Ru			Stete. Zip C	Code)
27 Is m ir traum		Alma W. Gilbert					prings Dr				.015
f itam 27 I		20e. Method of Disposition		20b. Ple		sition (Neme of netory or other p		Dete	20c. Location		
Important: If any injury or ance.		1 ☑ Burial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spe					. Gardens]	/17/98	Bel Ai:	r. Mar	ryl and
Important: If item any injury or othe once.		21. Signeture of Funeral Service Li	ensee		22 Ho	Name end Add	ress of Facility McComas	III Fun	eral Ho	me, P.	
	4	Milley a	Much		1:	317 Coke	sbury Roa	d. Abin	adon. M	210	09
		23a. Pert Enter the disease, or co shock, or mart failure. List or	mplications that caused ly one couse on each line	the death. e.	Do not ente	er the mode of dy	ring, such es cerdiac	or respiratory e	rrest,	1	oproximate ntervel Between
sician edical		In madiate Come (Fig.)			0				/		Onset end Deeth
miner		immediate Ceuse (Finel disease or condition resulting in deeth)	e. Ce	rele	-	vere	lun 1	ical	1		TTUL
	5			Due to (or e	s e conseq	uenca of):					
nsit .	Examiner		b								
the buriel-transit	Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events		Oue to (or e	s e conseq	uenca of):				i	
		Ceuse (Diseese or Injury thet Initieted events	c	to /o	_ 112-2-2-2						
0 0	Medicai	resulting in deeth) Lest	d	Jue to (or e	s a consequ	Jenca or):					
the ettendin	Physician/	Pert II. Other significant conditions		t not resulti	ng in the ur	iderlying cause g	iven in Pert I.	23b. Did	tobacco use co	entribute to t	he cause of death?
		ische	mic cur	deo	mue	south	5	1 🗆	Yes 2 No	3 Proba	bly 4 Unknown
hes been sign ye 2 should be	Completed by				0		J	24a. Wes	en eutopsy ormed?	eveil	e eutopsy findings able prior to pletion of cause eth?
page	5							10	Yes 200	10	Yes 2Q No
# 5	Be	25. Wes case referred to medical examiner?					26. Piece of Dec	oth (Check only	one)		
this ca	2	1 Yes 2 No	Hospital: 1 Inpatier		2/Outpatien	3□ DOA O	ther: 4 Nursing H	ome 5 Resi	denca 6 Oth	ner (Specify)	
After the funeral	ü	27. Manner of Deeth Naturel 5 Pending	28e. Dete of Injury (Month, Day	Year) 2	8b. Time of Injury	28c. Inj W		28d. Describe	how injury occur	rred	
the f	cat	2 Accident investigat 3 Suicide 6 Could no	he]Yes 2□No				
Director:	Certification:	4 ☐ Homicide determine		ry - At hom (Specify)	e, ferm, stre	et, factory, office	I/	281. Location (City or To	Street and Numb wn, State)	ber or Rural i	Route Number,
2 =	edical C	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of a	my knowle	edge, deeth	occurred et the	time, date end place	, end due to the	cause(s) end made	anner es stat	ted.
mplet	P −	one) 29b. Signeture end title of cartifier	end menner stat	ed.							
28		250. Signisture end title of cartiller				250. LIGH	ise number		29d. Dete signe	ia (Monti, De	oy, rear/
	-	David S	Dun				2239		JANNAM	1 15,1	558
1		30. Name end eddress of person with					- 1			•	
		31. Date filed (Month, Day, Yeer)	32. Registre			ALPHA	1				
State Registra			98 Julia	Signatur	Red						



Harford County Healtine #4a. 26 1/15/97 KDG Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath Weightman January Leona Lucy 4a. Facility Nama (If not institution, give street and number) Gereral Hosp. 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs.

Months Days Hours Min. 5. Social Sacurity Number 8. Data of Birth (Month, Day, Year) Days 1 □ M 2 🖾 F Yes 86 214-28-4993 Apr. 17, 1911 Usual Rasidance of Decedent 10a State 10h County 10c. City, Town or Location Harford Maryland Director Edgewood 10e. Straat and Number 10f. Zlp Coda 10g. Citizen of What Country? 21040 805 Edgewood Road

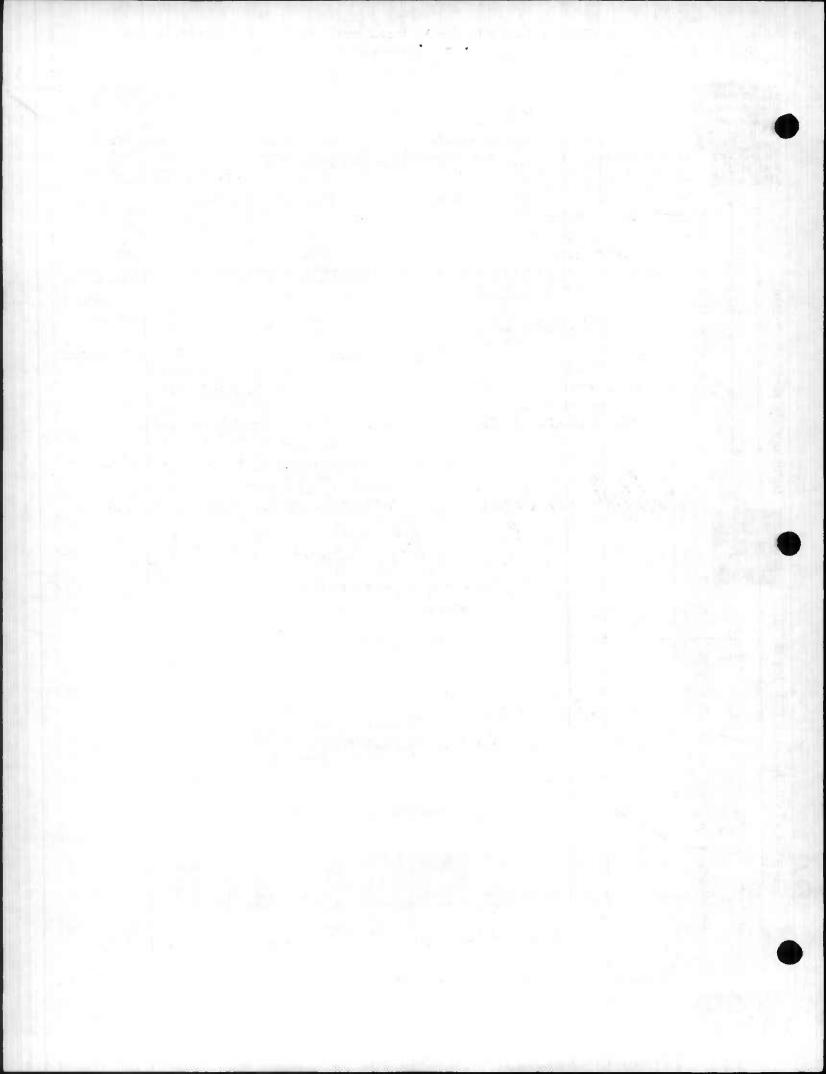
Physician 1640 /Medical Examiner Birthplace (State or Foreign Country) **Funeral** Director Maryland with the Maryland 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2 No ò "natural", or items 23a USA death Funeral 12. Was Decedant Evar in U,S. Armad Forces? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen indian, Black, Whita, atc. permit. Pages I and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Earn 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 X No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: by Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Forestry Service Secretary 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maiden Sumeme) Be Walter J. Lantz 2 Ada Louise Hanson 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Burt Dall - Brother-in-Law 838 Mill Creek Rd., Arnold, MD 21012 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Trinity Lutheran Church 1-11-98 Joppa, Maryland 21. Signature of Funeral Stryice Licenses 22. Nama and Addrass of Facility Howard K. McComas III Funeral Home, P.A. 23a. Party. Enter tha disaasa, or complications the shock, or haart failura. List only one ceuse 1317 Cokesbury RD, Abingdon, MD 21009 ceusad the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, Approximata Intervel Between Onsat and Death **Physician** /Medical Immadiata Causa (Final disaasa or condition resulting in deeth) 3mo Examiner Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immediata ceusa. Enter Underlying Ceuse (Diseese or injury that initiated avants rasulting in daath) Last P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): been signed by the a should be detached it Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Trobably 4 Unknown 1 ☐ Yes 2 ☐ No Records. Completed by 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? page 2 s ASCU certificate 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital director, 25. Wes cesa rafarred to medical axaminer? Be 26. Plece of Death (Check only one) Hospital: 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residance 6 Othar (Specify) 1 ☐ Yes 2 ☐ No Certification: To this funeral 27. Menner of Deeth 28a. Deta of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After 1 Natural 5 Panding Investigation 1 ☐ Yes 2 ☐ No hours after death. eral Director: A filled in by the f 2 Accident 6 Could not be detarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida To the Hospital of within 24 hours and To the Funeral ID completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and plece, end due to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and mannar stated. Medicai 29a, Certifian 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 03/322 01/86 30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) 4304 MTN. RD, PASADENA, Md 21/22 6A26 M

State Registrar

31. Data filad (Month, Day, Year)

32. Registrar's Signature

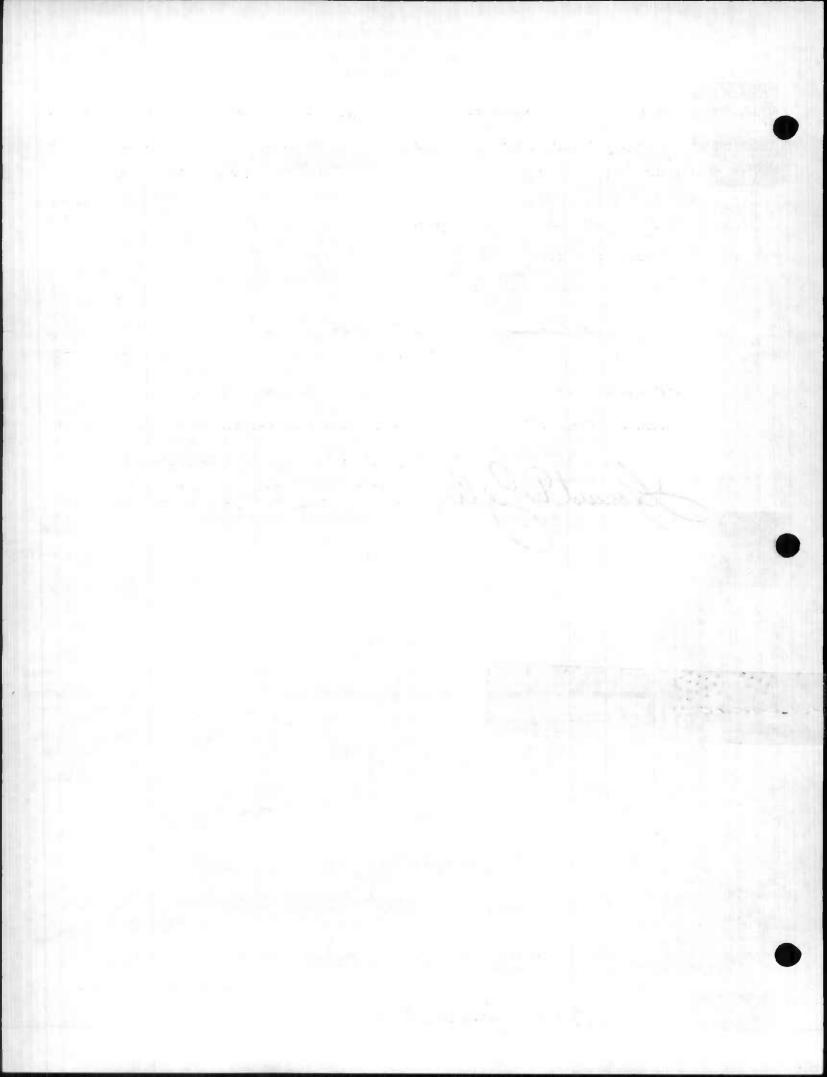


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Death **Physician** Month Year 14, 1998 Lawrence 1:35 AM Windsor January /Medical Howard 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Center: Genesis ElderCare If Undar 1 Yaar | If Under 24 Hrs. Hours | Min. Salisbury, MD Wicomico 6. Sex 1 ☑ M 2 ☐ F 8. Date of Birth (Month, Day, Nov. 5, 9. Birthplece (Stata or Foraign Country) Maryland 5. Social Sacurity Number 7. Age (In yrs. last birthday) **Funeral** Months 219-34-3815 60 Director Usual Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural; or items 23a or 28a-f ahow my injury or other traumatic event, "he Med can Examiner man to notified at 10d. Inside City Limits 1 TYes 2 N No Director Maryland Wicomico Salisbury 10e. Street end Number 10f. Zip Code 10a, Citizen of Whet Country? 701 Buckingham Circle 21804 USA Funeral 12. Was Decedent Ever in U,S. Armad Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 10 Freight Transport 17. Fathar's Name (First, Middla, Last) 18. Mother's Nema (First, Middle, Maiden Sumame) Be P Lawrence Windsor Nellie B. Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Lee Windsor/Son 1730 Riverside Drive, Salisbury, Maryland 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State Stephen's Cemetery 1/16/98 Delmar, Delaware 4 Donetion 5 DOther (Specify) 22. Nama and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802 1212 Old Ocean City Road, Sa carbons that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to cause operach ine. Parts' Enter the disease, or comp Approximate Intervel Between **Physician** /Medical Immediate Ceuse (Final MAN YEARS disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner attending physician end for use es the burial-transit Sequentially list conditions, if eny, leading to immadiate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the detached signed by t Yes 2□ No 3□ Probably 4□ Unknown Division of Vital Records, P 24b. Were autopsy findings available prior to completion of ceusa of death? should I 24a. Was en autopsy performed? Completed 22NO Somns 1 ☐ Yes ANO 1 Yes certificate funeral director, 25. Wes cese referred to medicel examiner? 26. Place of Death (Check only one) Hospital: 1 Yes ZZNo Other: Other: 5 ☐ Rasidence 6 ☐ Othar (Specify) 2 1 Inpatiant 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: After 1 Natural 5 Pending death. 1 ☐ Yas 2 ☐ No Invastigation i or Attend after death Director: / 2 Accident Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Hospital
 A Hours a
 Funeral D 29a. Certifier Medical Evertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) and menner stated. To the within 2 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUTHUS

1104 Healthway Dr., Salisbury, MD

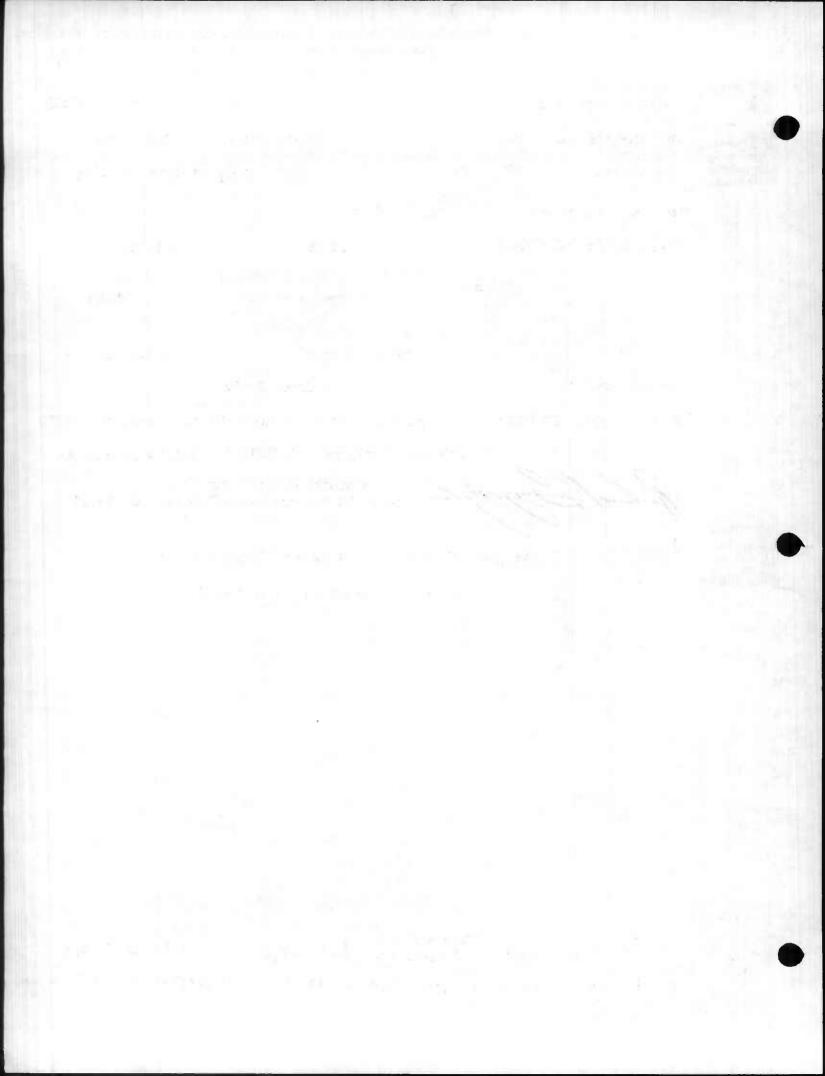
State Registrar 31. Dete filed (Month, Day, Year)

32. Registrar's Signature Whi Shudson Randall



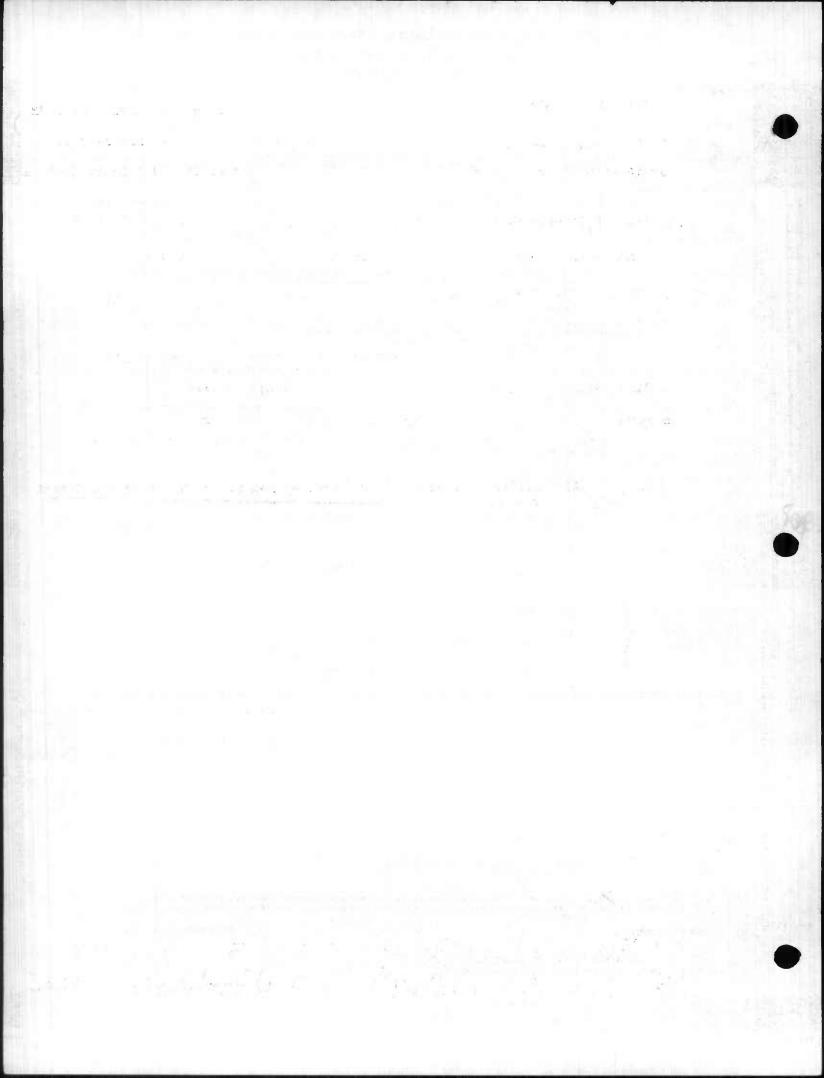
State of Maryland / Department of Health and Mental Hygiene 8 02 | 5

						Ce	rtificat	e of	Death		F	leg. No.		10.
Physician /Medical	_	. Decedent's Name (F Evelyn							4		2. Dete of Dee Month January	Day	9 9 8°	3. Time of De 15:55
Examiner		e. Fecility Name (If no 3817 Clark			m <i>ber)</i>				4b. City, To		cation of Deeth	40.7	y of Deeth Limor	9
Funeral Director		. Sociel Security Numb 217–07–255	8	Sex 1□M 22X F	7. Age (In yrs. I 86	est birthday) Yrs.	If Under Months	1 Year Deys		24 Hrs. Min.	8. Dete of Birth (Month, Dey July 20	Year)	Coun	lece (Stete or Fo try) Land
r 28a-f show notified at	1		b. County Baltimo	re		r, Town or Lo		:					1	0d. Inside City L
23a or 28a-f signature to a Director	1	0e Street end Numbe 3817 CLark	s Poir	nt Road			10f. Zip	Code 21	220		1	Og. Citizen of U.S.	What Coun	try?
xaniner in Examiner	Marital Status Never Married Widowed 4 □		12. Was Dece Armed Fo 1 Yes If Yes, Giv Yeer or De	2 No		Wes Deced It Yes, spec				ecify Yes or No- Rican, etc.)	Bla	ce - Americ ick, White, fy: Whit	etc.	
- 4 -		(Specify o		ade completed)		16e. Dece (Give life.	dent's Usue kind of wo DO NOT us	ol Occu rk done se retire	upetion e during mos ed)	st of work	ing	16b. Kind of E	Business/Inc	lustry
or than t		Elementery/Seconde		College (1	-4or 5+)		fice I					Heati	ng Oil	L
Mental Hygicarked other attic event, To Be Co	[7. Fether's Name (Firs August Re)						er's Nam Pu	e (First, Middle, i urdy	Melden Sumei	me)	
T is m traum	1	9a. Informent's Name Julia Koha		Type, Print)							e <i>i Rout</i> e Num <i>be</i>			
	2	0a. Method of Disposit 1 X Burial 2 □ C 4 □ Donation 5 □	remetion 3 [Removel from :	CE	lace of Disponentery, cremetery, cremetery	metory or o	ther of	aca) 1/	/30/1	Dete 1998	20c. Location Baltimo		
Department Important any injury once.	2	1. Signature of Funan			Al.	-					l Home venue E			
ding physician and sees the burne drament	s in contract of the contract	disease or condition esulting in death) Sequentially list condition in the condition of th	ons, diate 19 Ty		Due to (or Diff	es e consec	quenca of): H quenca of):				DISE	152		
een signed by the ettending phy hould be datached for use es th and by Physician/Med	P	ert It. Other significan	nt conditions c	ontributing to de	eath but not resu	iting In the u	nderlying c	euse g	iven In Pert	l.	23b. Dtd to	1.4		the cause of d
ple ple	-										24a. Wes e perfor	en eutopsy med?	col	ere autopsy tind eilable prior to apletion ot ceus deeth?
is cartificate he director, pega To Be Com		5. Wes case reterred	to modical						00 Bl	/ 5	1 🗆 Y		1 0	Yes 2□ No
this cartific rai director, To Be		exeminer? 1 ☐ Yes 2 No	io modical	Hospital: 1 ☐ I	npatient 2 1	ER/Outpetier	nt 3 DC	OA O	ther.		h <i>(Check only ol</i> ome 5 ½ Resid		her (Specif)	<i>'</i>)
within 24 hours efter death. To the Funeral Director: After the completaly filled in by the funeral Medical Certification:	27. Menner of Deeth 1 Maturel 2 Accident 3 Sulcide 4 Homicide 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28e. Place of Injury - At home, ferm, street, tactory, offica						No	28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
within 24 hours of to the Funeral Completaly filled	2			niner: On the ba	asis of examineti						end due to the o			
vithin To the comple	2	9b. Signeture end title	of certifier	end menn	TRE	ATIN	1		nse number	9		9d. Dete sign		
10	3	0. Neme end eddress			e of deeth (Item	YSICIA	-N -		1769			1-	28	.98
State Registrar	3	1. Dete tiled (Month, D		JU.M	egisher's Signet			LA	RD A	VE	, BA	LTIMO	KEI	MD-21



State of Maryland / Department of Health and Mental Hygien® 8 02155

		A December Name (Control of the Land			Certificate of	Death		g. No.		
Physi	cian	Decedent's Neme (First, Middle, La RICHARD	ADAMS				2. Dete of Deeth Month	Day	Year	3. Time of Death
/Med Exam		4a. Facility Neme (If not institution, giv				4b. City, Town, or Le	January Deeth	7 15, 19		6:10 PM
Exam	mer	3323 Mondawin A				Baltimore		Balti	more	City
Funera Directo		247 10 4010	Sex 7. Ag	e (In yrs. last bii 3	thday) If Under 1 Year Months Days		8. Date of Birth (Month, Day June 21	Year) 1914	9. Birthpl Count Sout	aca (State or Foreign Crolina
Du Marie	7	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location				10	d. Inside City Limits
death with the Maryland ms 23a or 28a-f show c.must be notified at	to	Maryland Baltimo	re City	Balti	imore					1 No 2 No
or 28e	Director	10e. Street and Number		l	10f. Zip Code		10	g. Citizen of W	hat Count	ry?
23a Can		3323 Mondawin Av	renue		21216			U.S.A.		
2 2 2	by Funeral	11. Merital Stetus 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces? 1 ☑ Yes 2 □ N If Yes, Give Yeer or Dates:		13. Was Decedent of If Yes, specify Cub		ecify Yes or No- Rican, etc.)	14. Race Bleck Specify:	, White, e	etc.
Maryland 21215-0020 02 should be filed within 72 hours ah th and Mental Hygiene. 7 is marked other than "natural", or traumetic event, the Medical Exami	Completed	15. Decedent's E. (Specify only highest gra Elemantary/Secondary (0-12)	ducation	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire			6b. Kind of Bus		
be filed v tal Hygie d other t event, th		17. Father's Neme (First, Middle, Last)	2		Construction	on Worker 18. Mother's Name		Constru		<u>n</u>
aryian thould be of Mental marked o	To Be	Walter Adams					e Burton		,	
C 25 M b	-	19a. Informant's Name/Reletionship (unknown	Type, Print)		. Mailing Address <i>(Stree</i> unknown	-			State, Zip	Code)
Pages 1		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Conetion 5 ☐ Other (Specification of the control o	y)	cemete	f Disposition (Name of ry, cremetory or other ple	oce)	Dete 2	Oc. Location - C	City or Tov	vn, Stete
Baltim permit. Pa Department Important: any injury		21. Signature of Funeral Service Licer Ronal d	Wade, D	irector		ess of Fecility atomy Boa e, Maryla	rd, 655	W. Balt	imor	e Street
		23a. Pal I. Enter the disease, or com shock, or haart fallure. List <i>only</i>	plications that caused one cause on each lir	the death. Do				st,		Approximete Interval Between Onset end Death
Physician /Medica Examine		Immediate Cause (Final disease or condition rasulting in death)	. Ohr	onec	Obst	rudiu	2/4	pno	7	Wally
	ē			Due to (or as a	consequence of):	Dire	010	/		11000
58/60 , tificate be axecuted g physician and es the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Undarfying Cause (Disease or Injury	b	Due to (or as a	consequence of):	alge	001	-		thor
	Medical	that initiated events resulting in death) Last		Due to (or es e	consequence of):					
BOX to sath certification attending for use as	Physician/N		d							
that the de delached idelached i	iysic	Part II. Other significant conditions of	ontributing to death be	ut not resulting In	the underlying cause gi	yen in Part I.	23b. Did tot			the cause of death?
requires that the death cer requires that the death cer seen signed by the attendir hould be detached for use	by	Cerebrar	ascel	202	Haci	deit	240 Wes es	onneans I		ably 4 Unknown
28 8	Completed						24e. Wes en perform		con	liable prior to npletion of cause leath?
VICIAN: The la certificate he rector, page		05 Western for the first					1□ Ye		1 🗆	Yes 2□ No
Physician: this certific	To Be	25. Wes case referred to medical examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatie	nt 2□ER/Ou	itpatient 3 DOA Ot	26. Place of Deat her: 4 ☐ Nursing Ho	11		· (Canalh	
Ing Ph After thi		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Data of Injui (Month, Day	y 28b.	Time of 28c. Inju		28d. Describe ho	nce 6 Other		
To the Hospital or Attending Physician 24 hours after deeth. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 Sulcide 4 Homicida 6 Could not be datarmined	28a. Place of Injubuilding, ato	ury - At homa, fa	rm, street, fectory, office		28f. Location (Str. City or Town,		r or Rurai	Route Number,
Hospital 24 hours Funeral idetely filled	edical (29a. Certifier (Check only one) Certifying Ph	ysician: To the best on niner: On the basis of end manner sta	examination an	o, deeth occurred et the ti d/or Investigation, in my	me, date and place, opinion, death occurr	and due to the cared at the time, da	usa(s) and man te end place, ar	nar as sta nd due to	ited. the cause(s)
To the within 2 To the comple	Me	29b. Signatore and title of certifier			29c. Licens	se number	29	d. Date signed	(Month, C	ay, Year)
		Christ	2 3	range	E Compa	3226	3	1/21	0	18
31		HRISTIE L	to ecuse beleigned	aath (Item 23a)	MD 19	40 W	Bolt	NOVE		21223
St Regis	ate	31. Date filed (Month, Day, Year)	32 Registre	r's Signature						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Jean Blake Austin 9:30 AM January 1998 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death 6225 York Road Apt. E-307 Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 X F 215-05-0716 86 Yrs. Usual Residenca of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Maryland Baltimore 1X Yes 2□No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6225 York Road Apt. E-307 21212 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Bookkeeper Social Services 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Edward Blake Dora (unknown) 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 9580 Castile Ct. Edward L. Austin / Son Columbia, Maryland 21045 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1-31-98 Holy Redeemer Cemetery Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility

Mitchell-Wiedefeld Home 21. Signature of Foneral Service Licens 6500 York Road Baltimore, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel diseese or condition resulting in death) Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 Unknown 1 Tes 2 No 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Natural 1 🗌 Yes 2 No 2 Accident

/Medicai **Examiner** Box 68760, 8 thet the death certificate for us bened b Records, The law requires certificate Division of Vital Hospital or Attending Physician: 24 hours effer death.
Funeral Director: After this certifica stelly filled in by the funeral director, t To the Hospital within 24 hours e To the Funeral Completely filled

Physician/Medical Be Completed by 2 Certification: Medical

3 Sulcide

29a. Certifler

4 | Homicide

29b. Signature and title of certific

Physician

/Medicai

Examiner

Funerai

Director

28a-f show

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Items 23a

permit. Pages 1 and 2 should be filed within 72 hours after to Depertment of Health and Mental Hyglena. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Expressions.

Physician

the

98 use

page 2

Baltimore, Maryland 21215-0020

Director

Funerai

by

Completed

traumatic event, the Medical Examiner must be notified at

State Registrar

La Devidson

6 Could not be determined

to completed cause of death (Item 23a) (Type, Print) m.D. 5601 32, Registrer's Signeture

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

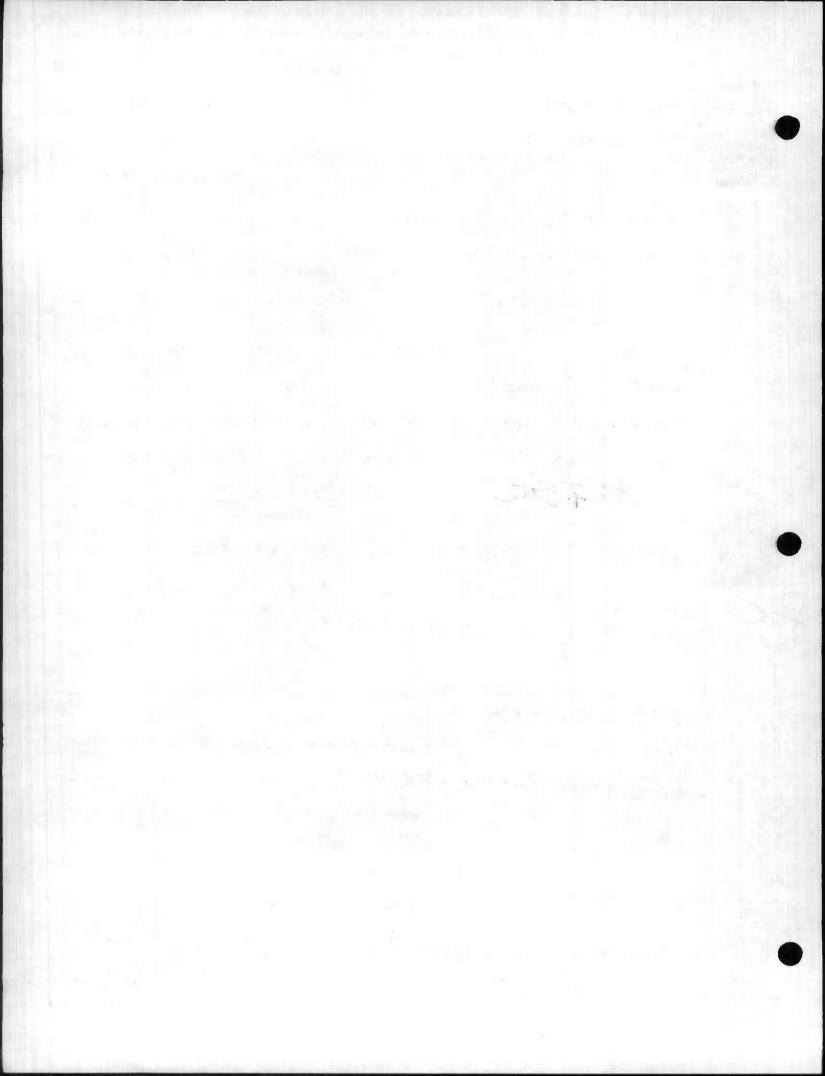
Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner steted.

29c. License number

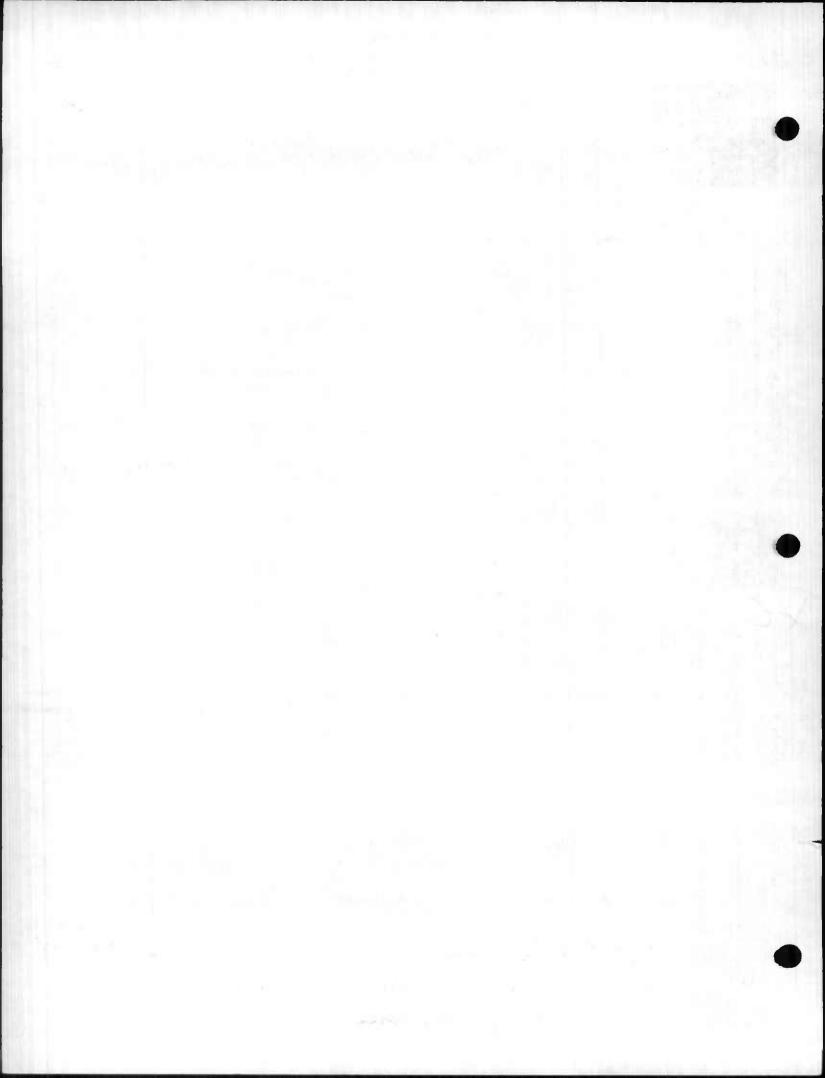
29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)



State of Maryland / Department of Health and Mental Hygiene 8

					Certifica	ale of D	eatri		Reg. No.	0	
.ielen	1. Decedent's Name (First, Mic	_						2. Date of Dea	ath Day	Year 3	. Time of Death
sician edical	Robie C	Bu	Her					Januar-		998	1-7-40
miner	4a. Facility Name (If not institut	tion, give s	street end number)					Location of Death	4c. County	of Death	
	Baltimore Vetera	ins A	dministrat	non Ho	ospital		Battimor				
ral or	5. Social Security Number 2 18 - 20 - (0666	6. Sax	7. Age M 2□ F	e (In yrs. last	birthday) If Un Month		If Undar 24 Hrs Hours Min.	(Month, De			(State or Forei
OI .	Usual Residence of Decedent	/-		4		1		4-19	1-1928		rice
	10a. State 10b. Cour	nty		10c. City, To	own or Location					10d.	Inside City Llmi
ğ	Md	1	VA	Ba	14 mor	.0					1 Yes 2 N
Director	10e. Streef and Number			000	10f.	Zip Code			10g. Citizen of N	Whet Country?	,
<u></u>	1500 More	fand	Augni	19		2/21	6		a.	S.A	
Funeral	11. Marital Status	,	12. Was Decedent I		13. Was De	cedent of His	panic Origin? (S	Specify Yas or No- to Rican, etc.)	14. Rac	e - American I	ndian,
2	1 Navar Married 2 M	larried	Armed Forces? 1 X Yes 2 □ N	No lo				to Hican, etc.)		ck, Whife, etc.	_ b)
þ	3 ⊠ Widowed 4 □ Divorc	bed	If Yes, Give Year or Dates:	12-22-	7₽ 1⊔ Yes	2 (1) No	Specify:		Specify	. pla	CIL
Completed	15. Deced (Specify only high	dent's Educ		16	Ba. Decedent's U (Give kind of	sual Occupat	on	dina	16b. Kind of B	usiness/Indust	ry
nple	Elementary/Secondary (0-12		College (1-4or 5		life. DO NO	Tuse retired)	rang most or wo	ikiig	Cho	uch	
5	Mengrade		NA		Cust	odian					
Be	17. Father's Name (First, Middl	la, Last)				1	8. Mother's Nar	me (First, Middle,	Maiden Sumen	ne)	
2	Kobie Bu-	tler					Victo	na U	Jaller	1	
1	19a. Informant's Name/Relatio	onship (Typ	oe, Print)	1	9b. Mailing Addr	ess (Street er	d Number or Ru	ural Route Numbe	r, City or Town,	Stete, Zip Co	de)
	Vinnie Gran	1 -	French		1500	Morelo	and h	prenue	Dal40,	Hd Z	1216
	20a. Method of Disposition			20b. Place	of Disposition (/	Vema of or other placa;		Date	20c. Location -	City or Town,	Stete
	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		emoval from Stafe	Gar	701500	Fores	+ 1 let	1-30-98	Dilling	as Mi	1/s Md
ė	21. Signature of Funeral Service	ce License	98	1	,23. Name	and Address	of Facility	+	UWITI	3 1111	2/2/5
	1 Cami	000	CIDA	P)	Man	L F.H	. West	had t	60.000	B-11	wel
	23a, Part 1, Enter the disease	or complic	cations that causad	the death D	o not enter the m	ande of dving	Such as cardia	correspiratory a	raci	Re 140	proximate
	23a. Part1. Enter the disease, shock, or heart failure. L	lsf only one	e cause on each lir	10.		,,				Int	erval Between set and Death
n al	Immediate Cause (Final										
	disease or condition resulting in deeth)	Θ.	1 uberc								
ē			_		a consequence	of):					
Examiner		b.	- Phew	monio-		-0.					
Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury				a consequence of	•				1	
Medical	Cause /Discourse in Course /Discourse /Disco	С.	Palmo	mary	embolis	m					
1	that initiated events			Due to (or as	a consequence o	я):					
1 0	fhat initiated events resulting in death) Last										
η/Me	mat initiated events	d.									
cian/Me	resulting in death) Last									- 1	
nysician/Me	mat initiated events			ut not resulting	g In the underlyin	g causa givan	in Part I.		obacco use co		
Physician/	resulting in death) Last			ut not resulting	In the underlyin	g causa givan	in Part I.		obacco use co Yes 2□ No		
by Physician/I	resulting in death) Last			ut not resultinç	g In the underlyin	g causa givan	in Part I.	188	yes 2□ No	3 Probabi	y 4 Unkn
by Physician/I	resulting in death) Last			ut not resultinç	g In the underlyin	g causa givar	in Part I.	1 🐼		3 Probabi	autopsy finding ble prior to ation of cause
by Physician/I	resulting in death) Last			ut not resulting	g In the underlyin	g causa givar	in Part I.	1 🐼	Yes 2□ No an eutopsy	3 Probabi	autopsy finding ble prior to altion of cause
Physician/	resulting in death) Last			ut not resulting	g In the underlyin	g causa givar	in Part I.	165. 24a. Was	Yes 2□ No an eutopsy	3 Probabi 24b. Were availat comple of dear	autopsy finding ble prior to ation of cause
Be Completed by Physician/I	resulting in death) Last	ical	tributing to death bu	ut not resulting	g In the underlyin		26. Place of De	165. 24a. Was	an eutopsy med?	3 Probabi 24b. Were availat comple of dear	autopsy finding alion of cause th?
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dey **Physician** Alice L. BIACK 9:10 PM JAN. 28 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 301 N. Montford AVE Baltimore NIA If Under 1 Year If Under 24 Hrs. 9. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) 10 M 20 F Months Deys Hours 219-50-4290 Usuel Residence of Decedent Yrs. **Director** 27,1939 10d. Inside City Limits with the Maryland 10a Stete 10b. County 10c. City. Town or Location 1 Yes 2 No MARYLAND BALtimore Directo NIA 7 is marked other then "neturel", or itema 23a or 28a-f treumetic event, the Madical Examiner must be notitle 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A 21213 Montford AVE 1301 death Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other than the state of the Bleck, White, etc. 1 Never Married 2 Married 1□ Yes 2□ No Specify þ BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bustness/Industry 15. Decedent's Education (Specify only highest grade completed) Etementery/Secondery (0-12) College (1-4or 5+) HEALTH CARE MAINTENANCE ENGINEER 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) SPERGEON WARREN LEE ELLA STEWART 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) FRANKLIN LA CHERYL BALtimore Md. 21215 5400 St. Charles 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Jan 31,98 Voshell's MEMORIAL 22. Name end Address of Fecility
RCNALD A. GRAYSON FUNERAL SERVICE 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. 21244 **Physician** PANCREATIC CANCER /Medical Immediate Cause (Finel 5 months disease or condition resulting in death) **Examiner** Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequença of) Box 68760 Physician/Medicai Due to (or es e consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? Division of Vital Records, P.O. 8 B 1 Yes 2 No 3 Probably 4 Unknown benga be da þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 1 No. certificate Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) Certification: To 1 Yes 20 No 1 ☐ tnpatient 2 ☐ ER/Outpatient 3 ☐ DOA gris 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Affier or Attending F after death. Director: After 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 8 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide To the Hospital of within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner stated. 29a. Certifier Medical

State Registrar

31. Dete filed (Month, Day, Year)

29b. Signature end title of certifier

301 FRANCISX, STRAM, III, U.D. 32. Registrar's Signeture a Devidson-Randall

30. Neme end eddress of person who completed cause of deeth (ttem 23e) (Type, Print)

M MI

29c. License number

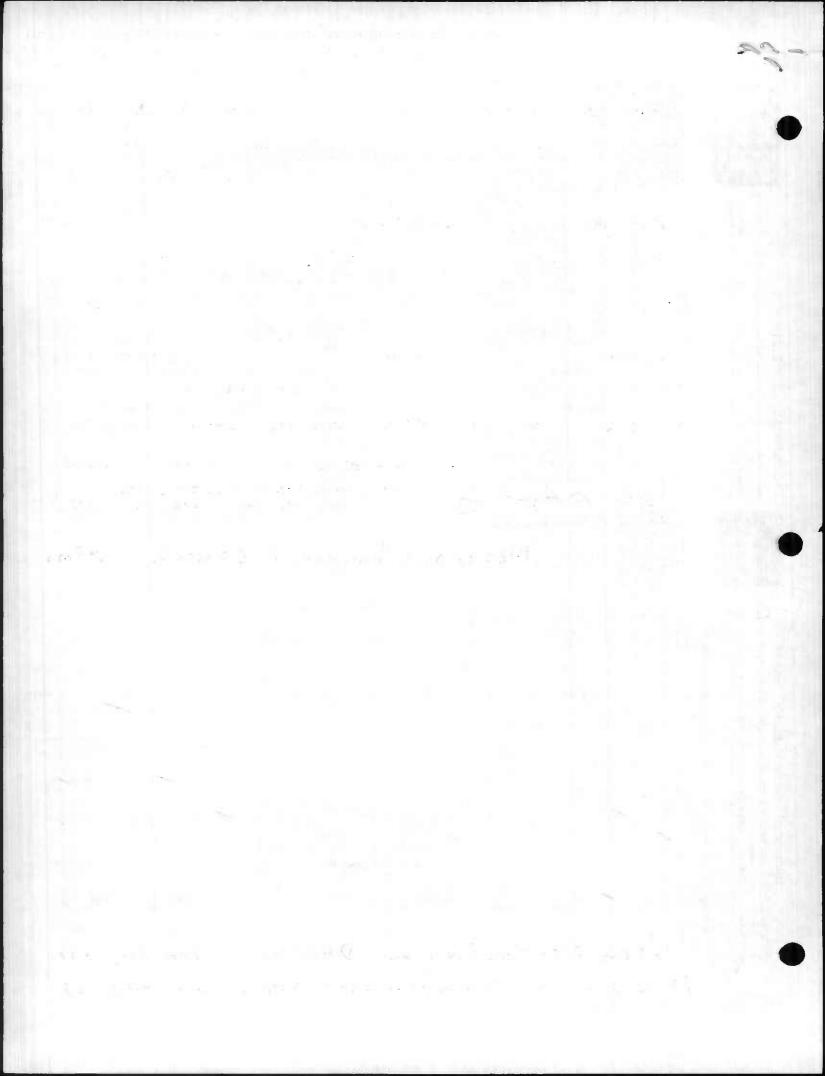
29d. Date signed (Month, Dey, Year)

STPAUL # 907 BAUM DI202

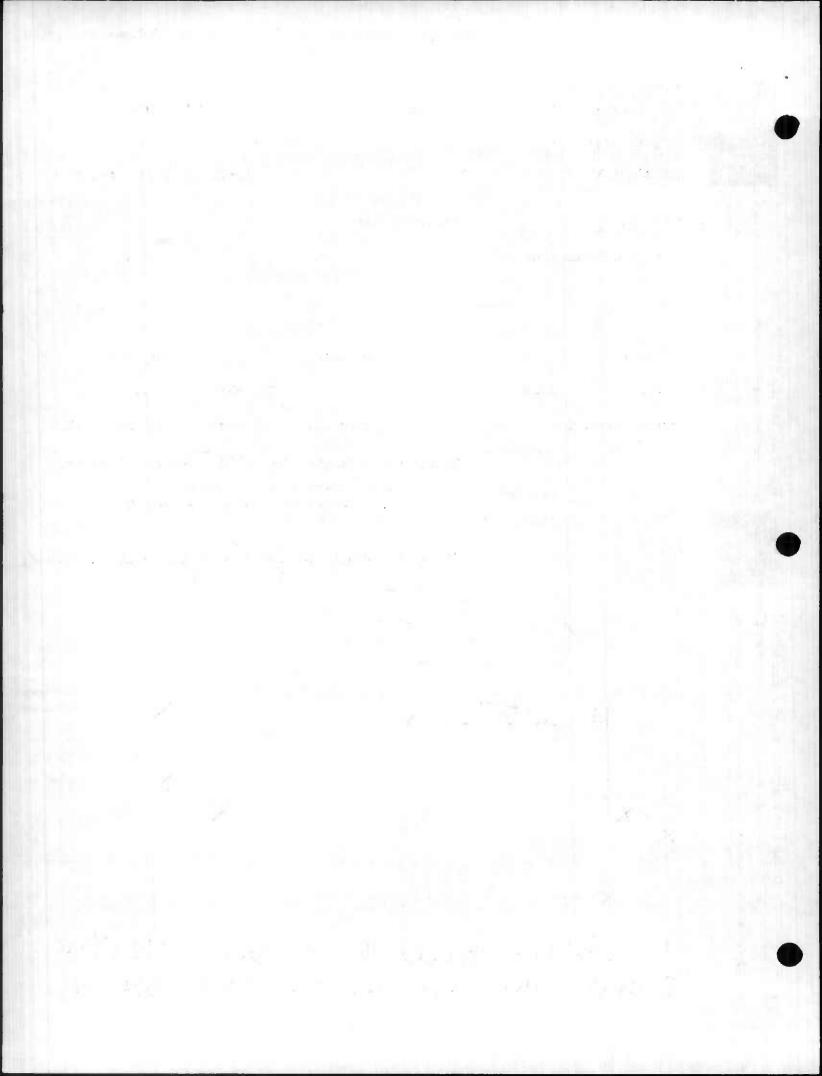
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State of Maryland / Department of Health and Mental Hygiene 8 02 | 59

				C	ertifica	ate of	Death		Reg. No.	0 2	_ 1 0 2
11		1. Decedent's Nema (First, Middle, L	ast)					2. Dete of De	eth		3. Time of Deeth
Physic /Med	ical	CATHRYN ARNETT				1	4) City Town		Dey 26, 19		6:30 AM
Exam	ner	4e. Fecility Name (If not institution, g						r Location of Deet		y of Deeth	
	7	4903 Old Court 5. Sociel Security Number 6.		In yrs. last birthda	ul If Und	ler 1 Year	Randal I			imore	
Funera Director		214-14-3833 Usuel Residence of Decedent	1 M 2 M E	6 Yrs.	Month				, 1921	9. Birthpi Count Mary	leca (State or Foreign try) land
ylend	1	10a. Stete 10b. County	1	0c. City, Town or	Location					10	0d. Insida City Limits
Mer a-f al	cto	Maryland Baltimo	ore	Randa1	1stow	'n					1 ☐ Yes 2 ☒ No
or 28	Director	10e. Street end Number			10f. 2	ip Code			10g. Citizen of	Whet Count	try?
ath w	- Fa	4903 Old Cour				2113	33		USA		
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filled within 72 hours efter death with the Meryland Seperiment of Health and Mental Hygiene. mportant: if liem 27 is marked other than "natural; or items 23e or 28e-f show my injury or other traumatic event, the Medical Examinar manuals and and more.	by Funeral	11. Marital Status 1 □ Naver Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Wes Decedent Even Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	er In U,S.	If Yes, sp	ecify Cub	Hispanic Origin? (en, Mexican, Pue Specify:	Specify Yes or No into Ricen, etc.)		ce - Americe ick, White, e	etc.
5-0 72 ho	ted	15. Decedent's I (Specify only highest g	Education	16a. Dec	edent's Us	uel Occu	pation during most of w	nakina	16b. Kind of B	lusiness/ind	lustry
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and the file and othe event,	Be	17. Father's Neme (First, Middle, Las						ame (First, Middle		ne)	
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or 1 end of Health litem 27 in other tr		Penny Cable 20e. Method of Disposition	(Daughter)	20b. Plece of Dis	position (N	ame of	reek Rd.	Date	7111e, N		21208 wn, Stete
Pages nent of Pages nent of Pages nert of Pages nert of Pages nert of Pages nert of Pages nert or or or or or or or or or or or or or		1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Spec		Cemetary, C							
Baltimo permit. Page Depertment of Important: If any Injury or once.		21. Signature of Funeral Service Lice					ss of Facility	1-27-98	Laurel	, Mar	yıand
Bal permit permit permit mpo		Moln K	and I					al Direc			
		23a. P. Enter the disease, or cor	nplications that caused th					Randalls			1133 Approximete
Physician		shock, or heart feilure. List only	y one ceuse on each line.								Intervel Between Onsat and Deeth
/Medical		Immediate Cause (Final disease or condition	· META	STATIC	Pr.	100	EATER	(A)	ICED		>8mu.
Examiner		resulting in death)		e to (or es e cons			CENTIC	CIT			7 01110.
7 = =	Examiner	_								i	
rensit	xam	Sequentially list conditions,	Du Du	e to (or es a cons	equence o	l):					
Box 68760, eath certificete be exettending physician for use es the buriel		if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events	C. ———								
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Certification of the second of			d								
death certification of for use 6	Physician/	Death Other death					5-X - 17	1			
O # # P	hys	Pert II. Other significant conditione	contributing to death but r	ot resulting in the	underlying	ceuse gi	ven in Pert I.			_	the cause of death?
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SCOFC sw requir	Completed b								en eutopsy omed?	com	re eutopsy findings alleble prior to appletion of ceuse deeth?
The lew	mo;							1 🗆	Yes 22No	1□	Yes 2₽No
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of Vita Physician: rithis certific	2	1 Yes 2 No	Hospitel: 1 ☐ Inpatient	2 ER/Outpati	ent 3□ [OOA Ot	ner: 4 Nursing	Home 5, ☐Resi	dence 6 □Oti	ner (Specify)
Division of Vita of or Attanding Physician: after death. Director: After this certification by the funeral director.	ation:	27. Manner of Deeth 1. ■ Neturel 5 □ Pending 2 □ Accident investigation		ear) 28b. Time injury		28c. Inju Wo 1	ryet rk? ∣Yes 2 □ No	28d. Describe	how injury occu	rred	
Division Attracts at Directs led in by the	Certification:	3 Suicide 6 Could not learnined		- At home, farm, s Specify)	street, fecto	ory, office		28f. Location (City or To	Streat and Number, Stete)	ber or Rural	Route Number,
DIVI To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Pl (Check only one) 2	nysician: To the best of m miner: On the besis of ex end menner stated	aminetion and/or	ath occurre investigetion	d et the ti on, in my e	me, dete end pled opinion, deeth occ	ce, end due to the curred et the time,	ceuse(s) end m dete end place,	enner es ste end due to	eted. the ceuse(s)
To To To To To To To To To To To To To T	Σ	29b. Signa ura and title of certifier			2		sa numbar		29d. Data signe	d (Month, D	lay, Year)
4		Fles ATT	ENDING PO	4459210	7	D	40390)	JAN. 2	16.1	1998
5		30. Neme end eddress of person who	completed cause of deet	h (Item 23e) (Type	e, Print)		0			1	
		1.L-DESAL, MA- 31. Date filed (Month, Day, Year)	5310 000	COUNTI	20,7	305	KANDA	tusto	NN, M	321	133
Sta Regist	_	JAN 29	1998 SZ. Hegistrara	Signature .	Manda	32			•		

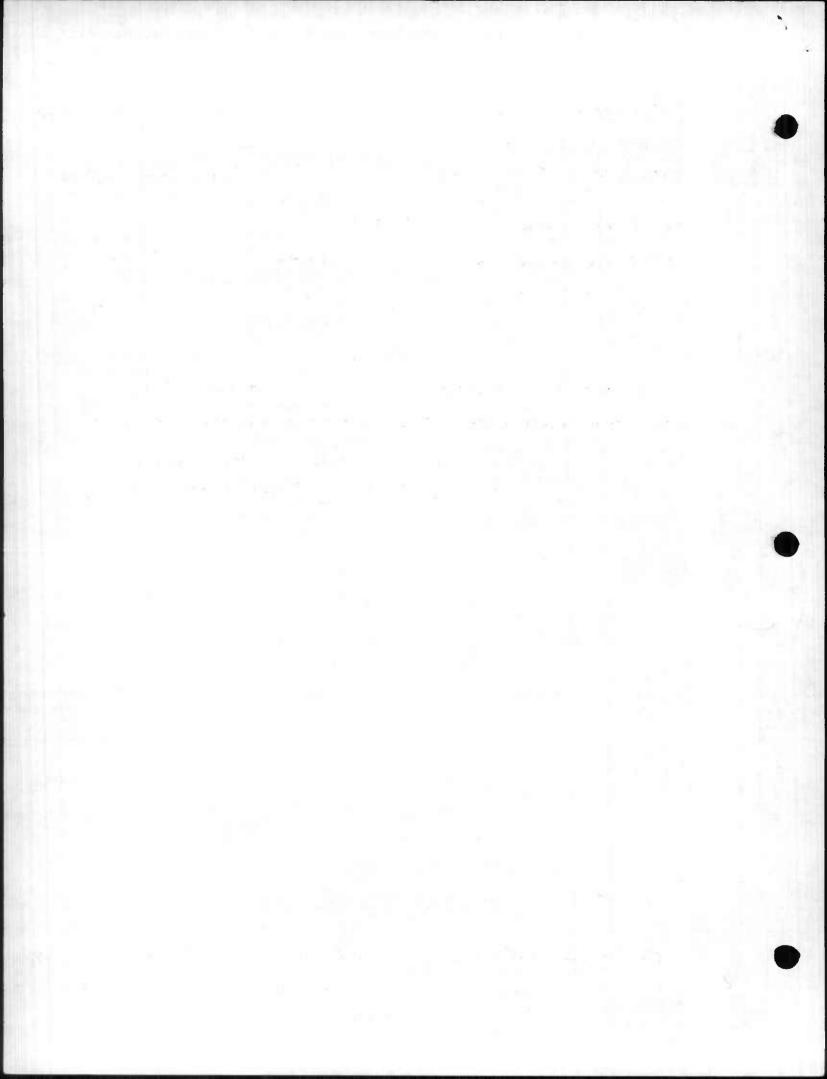


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Physic /Medi		1. Decedant's Nama (First, Middla, Eleanor	Peggy	Blayloc	ck				27, Day 1998	Yaer	1:00 AM
Exami Funeral Director	ner	212-30-0176	Avenue	ga (In yrs. last i	birthday) Yrs.	If Undar 1 Year Months Days	Baltin If Undar 24 Hrs. Hours Min.	MOTE 8. Date of Bir (Month, Da	N/A	9. Birthplace Country)	a (Stata or Foreign York
Marylend f show	ior	Usual Residance of Dacedant 10e. Stata 10b. County Maryland N/A	Δ	10c. City, To	own or Loc					10d.	Insida City Limits 1 Yes 2 No
th with the 23a or 28a	ai Director	10e. Street and Number 3414 Orlando		Dares	LMOTE	10f. Zip Coda 212	34		10g. Citizen of Wh		,
5-0020 72 hours after death with the Maryland natural, or items 23s or 28s-f show nicel Examines must be notified at	by Funeral	11. Maritel Status 1 □ Navar Married 2 □ Marrie 3 ☑ Widowad 4 □ Divorced	12. Was Decedant Armed Forcas d 1 Tyes 2 Hyas, Giva Yaar or Datas:	? ! No		as Decedant of H Yas, specify Cuba	ispanic Origin? (Si an, Maxican, Puart Specity:	pecify Yas or No o Ricen, atc.)	14. Race Black, Specify:	American I White, etc.	
TT 6 5 3	Completed	15. Decedant's (Specify only highast Elementary/Secondery (0-12) 9 Years	Education grada complated) College (1-4or		(Giva ki lifa. Do	ont's Usual Occup ind of work dona O NOT use retired Homemake	during most of wor	king	16b. Kind of Bus	nass/Indust	
laryland 212 2 should be filed withi and Mental Hygiene. Is marked other then aumetic svent, then	To Be C	17. Father's Nema (First, Middle, La John	Brown				18. Mothar's Nam	anche	Maidan Sumama, Unknow	n	
Baltimore, Ma permit. Peges 1 and 2 st Dependent of Health an important: If item 27 is any injury or other traur ance.		19a. Informant's Name/Ralationship Robert Blaylock 20a. Mathod of Disposition 1□ Burial 2 型 Cremation 3 4□ Donation 5□ Other (Spe	(Son)	20b. Place	Brue of Disposi tary, crame	cetown C tion (Nama of atory or other place	ourt Cat	tonsvill Data	e, Maryl 20c. Location - C	and ity or Town,	21228 State
Baltimol permit. Peges Depertment of Important: If it any Injury or o		21. Signature of Funaral Servica Lie	censaa Ayul	1	Lo:	Nama and Addra ring Bye 28 Liber	rs Funera ty Road	al Direc	Laurel, tors, In stown, M	с.	133
Physician /Medical Examiner	ər	23a. Part 1. Entar tha disaesa, or co shock, or haart failura. List or Immediata Causa (Final disaesa or condition resulting in death)	omplications that cause nly ona cause on aach	Dua to (or as	o not entar	the mode of dying the mode of	0		rrast,	On	proximata arval Batween isat and Death
68760, Illicate be send and g physician and as the burish ranat	ledicai Examiner	Sequantially list conditions, if any, leeding to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated events rasulting in daath) Last	b	Dua to (or es			V				
P.O. BOX 6 at the death certif f by the attending etached for use as	Physician/M	Part II. Other significant conditions	d.	out not rasulting	in tha und	larlying ceusa giv	an in Part I.	23b. Did	tobacco usa conti		e cause of death?
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of Vital Records, Physician: The law requires in this certificate has been significated that the control of the	Be	25. Wes cesa rafarrad to medical axaminar?	Hospitel:			045	26. Placa of Daa	th (Check only o		1 □ Yε	
On of ding Phys After this funeral d	Certification: To	27. Manner of Death Natural 5 Panding Invastigal 3 Suicida 6 Coule mind	28a. Date of Inju (Month, Date	ay Year) 28b	Outpatient Time of Injury farm, strea	3 DOA Oth 28c. Injur Worl 1 Latt, factory, office	4 LI Nursing H	28d. Describe	dance 6 □Othar now injury occurrace Street and Number	j	oute Number,
DIVISION To the Hospital or Attentiviting 24 hours after deal To the Funeral Director: completely lilled in by the	edical Cert	29a. Cartifiar (Check only 2 Medical Ex	Physician: To the best	of my knowled	ga, daath d	occurred et the tin	ne, data and place, olnion, death occur	City or Too	cause(s) and menr	ner as stete	d. a ceuse(s)
To the within 2 To the comple	Med	29b. Signatura and titla of certifiar	and manner st	AL A	ol.	29c. Licans			29d. Date signed		
Sta	te	30. Nama and addrass of parson who SAUGEL 31. Deta filed (Month, Day, Year)	MD	daath (Itam 23a	(Type, Pr	,	AUE	BALT	: 40	2121	01
Registr		JAN 2	9 1998	Julia Day	Adams_	Branda 00					



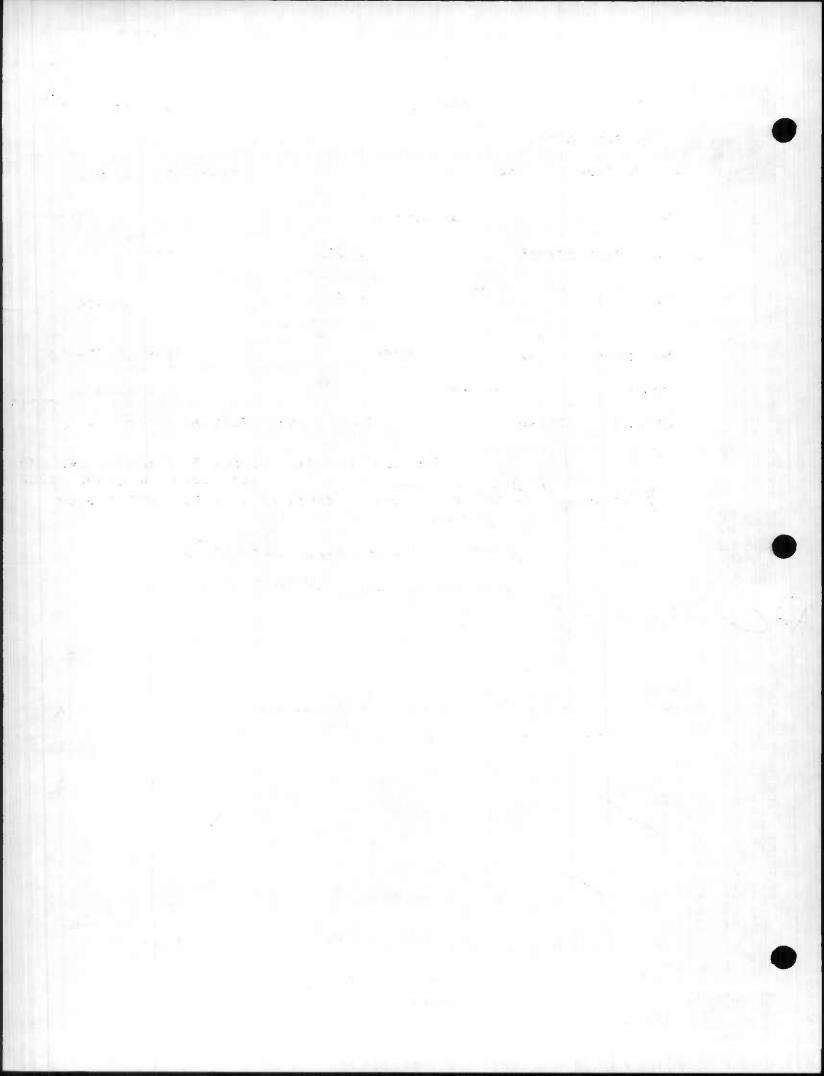
State of Maryland / Department of Health and Mental Hygiene 8 02 16 1

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State of Maryland / Department of Health and Mental Hygiene 8 02 162

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Beddoe 12:10 PM Evelun 98 01 27 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore, MD | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | 1913 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 84 1 M 2 R F 213-26-2907 Yrs. Pennsylvania Usuel Residence of Decedent 10b. County

Baltimore 10c. City, Town or Location 10d. Inside City Limits Maryland **Essex** 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1000 Franklin Avenue Apt. 509 21221 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②XNo If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 X Divorced White 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) **Housewife** Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Charles Tollberg Maude Holmes 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Joan M. Bloodsworth (Daughter) 9312 Shadey Creek Way Parkville, Md. 21234 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 Cremetion 3 ☐ Removal from Stete Greenmount Crematory 1/30/1998 5 Other (Specify) Baltimore, Md. 4 Donetion Bruzoziński Funeral Home P.A. 1407 Old Eastern Avenue one that caused the death. Do not enter the mode of dylng, such es cerdiac or respiratory errest, Approximete Intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in death) 48 hours pneumonia Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 YUnknown 24b. Were eutopsy findings eveileble prior to completion of cause 24e. Was en eutopsy performed? 1 Tyes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medice 26. Plece of Deeth (Check only one) Hospital: 1 → Impatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28c. Injury et Work? 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Naturel 2 Accident

1 Yes 2 No

15 Certifying Phyeicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and menner es steted.
2 Medical Exeminer: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29c. License number

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29d. Dete signed (Month, Dey, Year)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show

6

items 23a

6

"natural"

permit. Peges 1 and 2 should be filed within 7. Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "na any injury or other traumatic event, the Media once.

the Medical Examiner must be notified at

Funeral Director

Completed by

Be

the Marylend

filed within 72 hours efter death with

21215-0020

Baltimore, Maryland

The law requires that the death certificete the attending phys I signed by the

Division of Vital Records, P.O. Box 68760

Physician/Medicai by Completed Be 2

After this certificate hes Certification: Director: in by the edicai

or Attending Physician: death. efter

within 24 hours eff To the Funeral Di completely filled Ir the

State Registrar

31. Dete filed (Month, Dey, Yeer) 29 1998

5 Pending

3 Suicide

29a. Certifier

4 Homicide

29b. Signeture end title of certifier

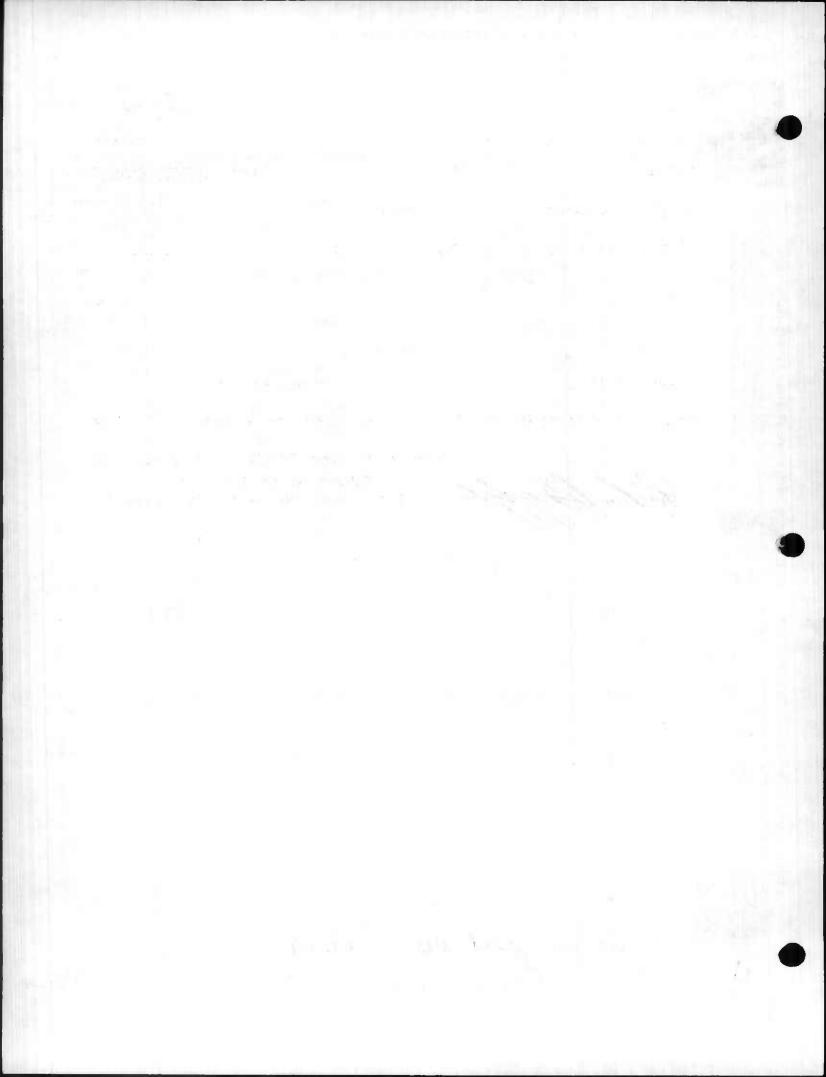
investigation

30. Name and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

6 Could not be determined



28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)



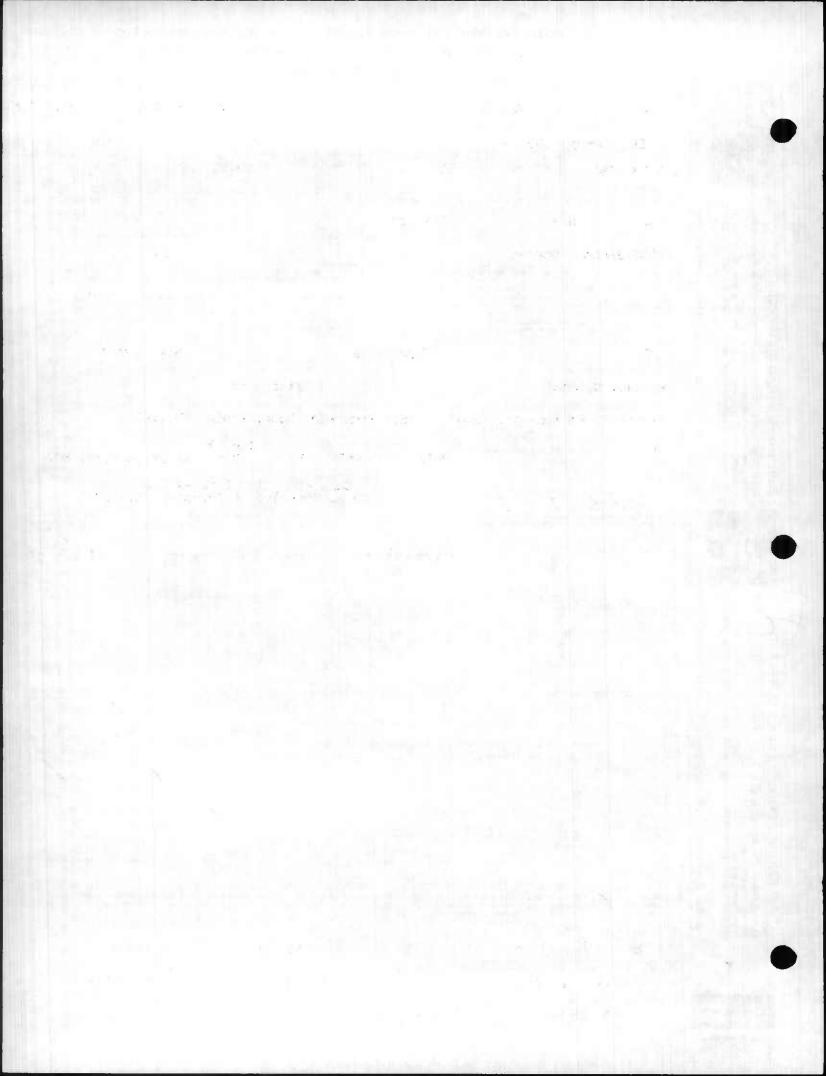
State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene 3 6 6

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) Month Day Yaai JAN. 24 1998 8:06 P.M. ALFRED CARL BEHR 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) GOOD SAMARITAN HOSPITAL BALTIMORE CITY If Under 24 Hrs. 8 Data of F N/A If Undar 1 Yaar 6. Sax Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Months Days Hours Min 1⊠M 2□ F Yrs. 216-05-7331 GERMANY 83 10/31/14 Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No BALTIMORE CARNEY 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Numba 14 WHITE SPRUCE COURT 21234 USA 14. Race - Amarican Indian, 12. Was Dacadent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 2 ☒ No Spacify: 3 Widowad 4 Divorced WHITE 16a. Decedant's Usuel Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) (Giva kind of work dona during most of working lifa. DO NOT use ratired) DAVIDSON TRANSFER & Elementary/Secondery (0-12) College (1-4or 5+) STORAGE CO. 8th GRADE TRUCK DRIVER 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) HADWIG ANNA DOMKE OTTO L. BEHR 19b. Mailing Address (Streat and Number or Rurel Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 21234 ELSIE S. BEHR WIFE 14 WHITE SPRUCE COURT BALTIMORE, MD 20b. Placa of Disposition (Nama of camatary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) DULANEY VALLEY MEM. GAR. 1/28/98 COCKEYSVILLE, MD 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility JOHNSON FUNERAL HOME, P.A. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onsat and Death Immediata Causa (Final CARDIOVASCICAR DISPASE disaase or conditio rasulting in deeth) MELLITUS Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disease or injury that initiated evants rasulting in daath) Last BLOOD 23b. Did tobacco use contribute to the ceuse of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings avaitabla prior to complation of causa of daath? 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No 2 19 No 1 Yas 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☑ DOA

/Medical **Examiner** 6876

Physician

Physician

/Medical

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Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after death variety of Mental Hygiene.
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State Registrar

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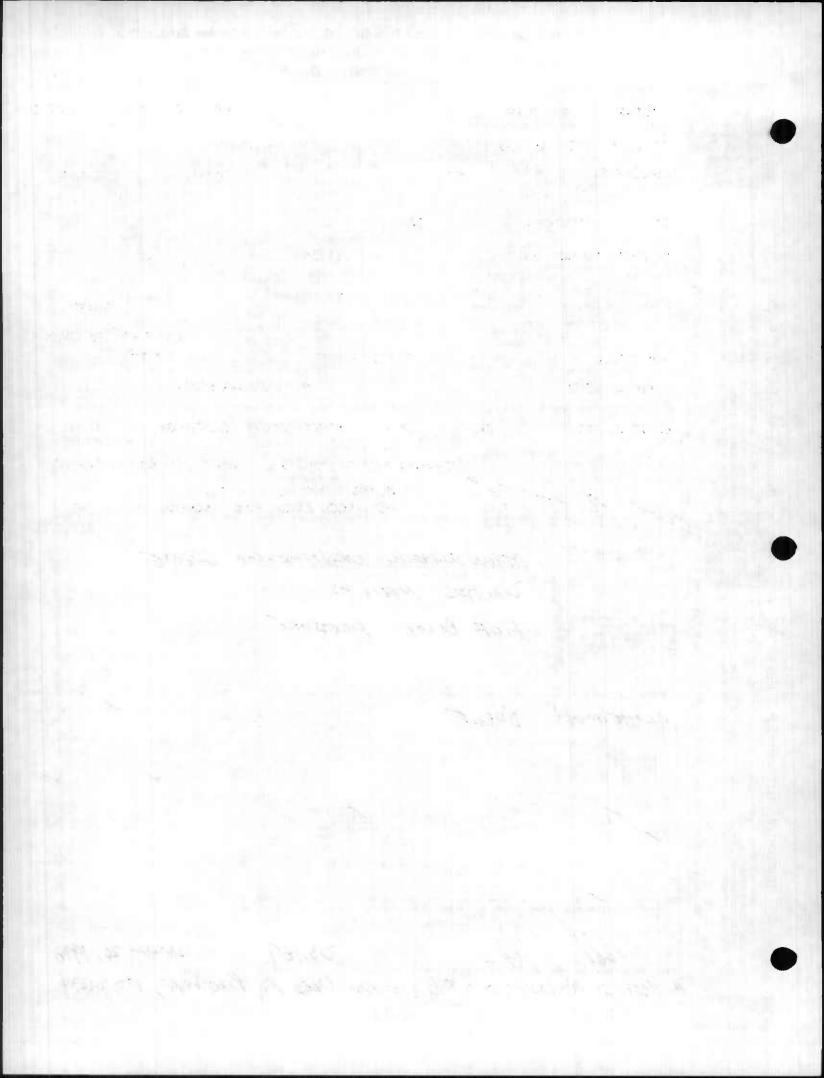
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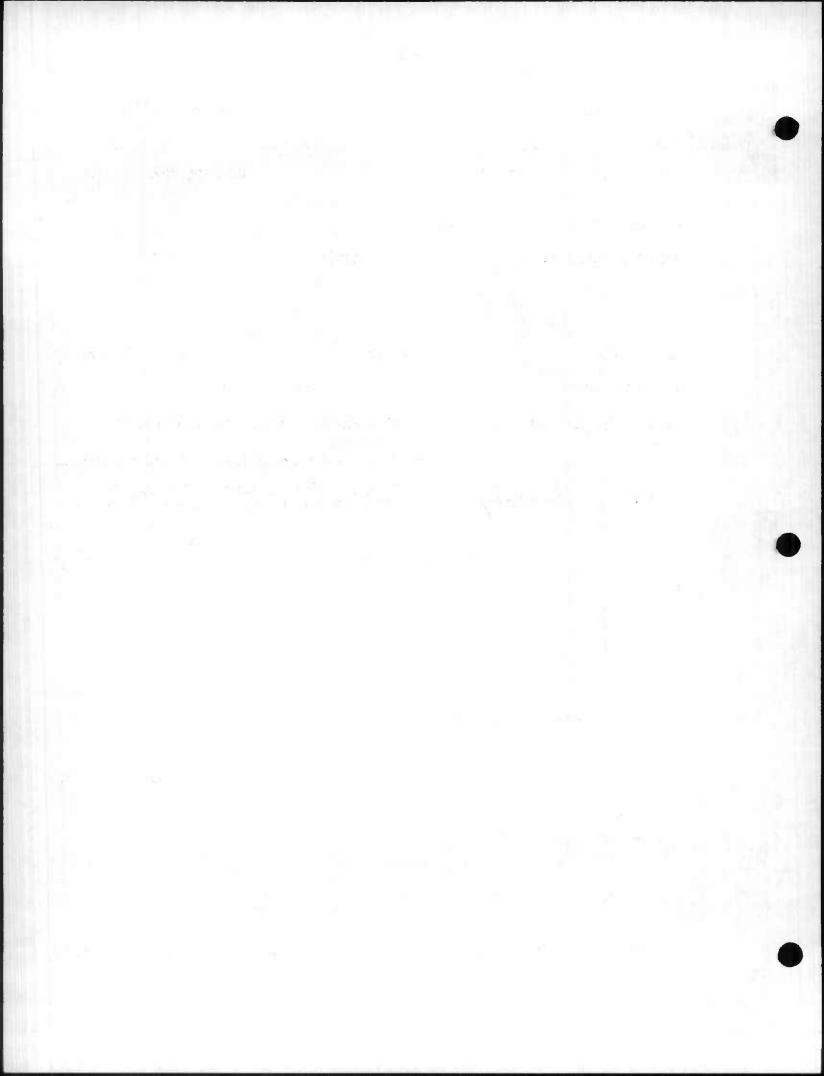
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cati	2 ☐ Accidant invastigation			М	1 [Yes 2 No				
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edical	29a. Cartifiar Certifying Ph (Check only one)	yalclen: To the best of ninar: On tha basis of and mennar sta	axamination and	, death occurred/ d/or investigation	d at tha t n, in my	ima, date and plac opinion, daath occ	ea, and due to the curred at tha tima	ceuse(s) and m , date and place,	annar as stat and due to ti	ted. ha causa(s)
Ž	29b. Signature end titla of certifier			29	c. Lican	sa number		29d. Date signe	d (Month, De	ay, Yaar)
	1 Dans 5	Dum			D 3	2299		Jerma	428.	195 8
	30. Nama and addrass of person who			Type, Print)	1			0	0	
	P.S. QIANG	UNN CIT		acPhai	/					
ate	31. Data filed (Month, Dey, Yaar)	32. Registra	ar's Signetura	0 445						
rar	JAN 29 199	8 galia	Devidson-1	jandelle						
3.08										



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** January 25, 1998 9:50 A.M. Bohnenberg Elizabeth Franz /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore

H Under 1 Year H Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Time 2, 1904 Lorien Frankford Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 20 F Mary Land 215-24-5836 93 YES Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1₺Yes 2☐No Director Maryland N/A 28a-f Baltimore City 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 U.S.A. 5009 Frankford Avenue 21206 items 23a Funeral 12. Was Decadant Evar in U,S. Armed Forces? 1 ☐ Yas 2 M No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yas or No If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - Amarican Indien, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 6 1 ☐ Yes 2 No Specify: by 3 Widowed 4 □ Divorcad Specify: White "natural", Completed 16e. Decedent's Usual Occupetion (Give kind of work dorse during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementery/Secondary (0-12) 8th Grade College (1-4or 5+) Sales Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider: Sumame) F. Charles Freitag Elizabeth Franz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Helen F. Fink/Sister 5916 Brackenridge Avenue, Baltimore, Maryland 21212 20b. Place of Disposition (Name of cametery, crematory or other place) 1/30/98 Dete 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State Baltimore/Washington Crematory Laurel, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Peneral \$ 22. Name end Address of Facility John C. Miller, Inc.
6415 Belair Road, Baltimore, Maryland 21206
Approximet
List only one cause on each line.

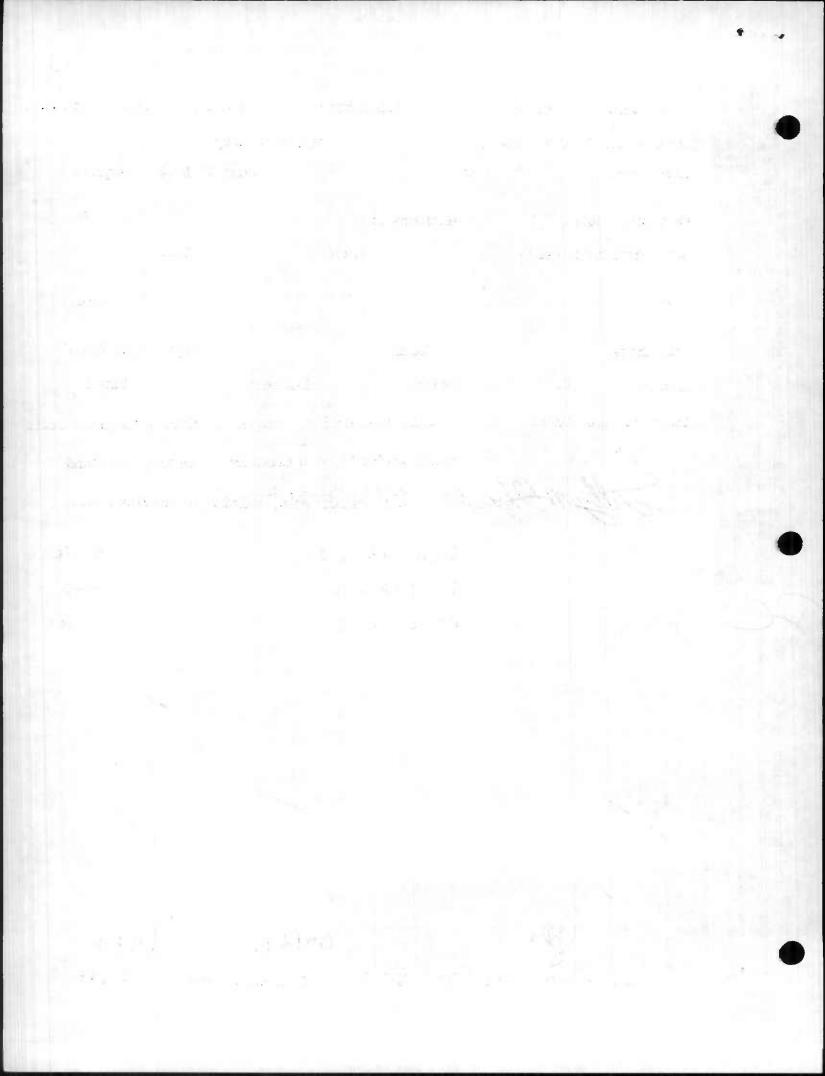
Approximet Approximete Interval Batwaen Onset end Deeth **Physician** /Medical Immadiata Cause (Final DEHLOMATION disaesa or condition resulting in death) Examiner Due to (or as a consequence of) Examiner DYS9HAGIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequence of) BRKINSONS Box 68760 Physician/Medicai Due to (or es e consequence of): 3 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ħ signed be del b þ 24b. Were eutopsy findings aveilable prior to Completed 24a. Wes en eutopsy performed? completion of causa of deeth? page 2 2 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was cese referred to medical 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Hospital or An.
 hours after death.
 vi Director: After
 vi by the IV. After Attending 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not ba 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 12 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated. edicai 29a, Certifier 29d. Data signad (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) MILLS C POSS 10,005 OR. I OWINGS 31. Date filed (Month, Day, Year) 32. Registrar's Signeture
The Daydon-Randelle State

DHMH 16 Rev 6/95

Registrar

29 1998

JAN



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 23, 1998 4:00 A.M. BARNHEART January Floyd Harvey 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Rosedale Baltimore Franklin Square Hospital Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Deys 18 M 2□F Months Hours Dec. 23, 1919 West Virginia 78 220-07-4781 Usuel Residence of Decedent 10a State 10b Counts 10c City Town or Location 10d Inside City I Imits Maryland Baltimore County Baltimore 1 Tyes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21221 l Eastern Boulevard 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11 Maritel Stetus Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Construction Laborer 5th Grade 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Matilda Ruoff Marie Frank Barnheart Harvey 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 9300 Orbitan Road, Baltimore, Maryland 21234 William Lewis Ortloff/Brother 20b. Place of Disposition (Name of cemetery, cremetory or other place) Holly Hill Cemetery Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 X Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 1/24/98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) vice Licensee John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 23a. Pent. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel 2 Days Pseudomonas Pneumonia disease or condition Due to (or as e consequence of): 2 Days Respiratory Failure Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es e consequence of): Chronic Obstructive Pulmonary Disease that initiated events resulting in death) Lest Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other stanificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to 24e. Was en eutopsy performed? completion of cause of deeth?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Directo

Funeral

by

Completed

7 is marked other than "natural", or frame 23a or 28a-f show traumatic event, the Medical Examinat must be notified at

ified within 72 hours after di Hygiene. other than "natural", or item

permit Pages 1 and 2 should be file
Department of Health and Mental Hy
Important: If frem 27 is marked oth
any injury or other traumatic event

Baltimore, Maryland 21215-0020

68760

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Records.

Division of Vital

Hospital

2

the Maryland

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death

Examiner Physician/Medical 2 # 8 94 signed by ģ 8 Completed ueeq page 2 28 certificate Be P 1 Certification:

funeral Atter

law. Physician: Attending Director or A 24 hours a

within 2

Registrar

State

edicai

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth 1 Neturel 5 Pending 2 Accident 3 Suicide

4 \ Homicide

(Check only one)

29b. Signature end title of certifier

29a. Certifier

investigation 6 Could not be determined

28e. Dete of Injury (Month, Dey Year)

Hospital:

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

RD 2116

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

29d. Date signed (Month, Dey, Year) January 23, 1998

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 ☐ Yes 2 ☐ No

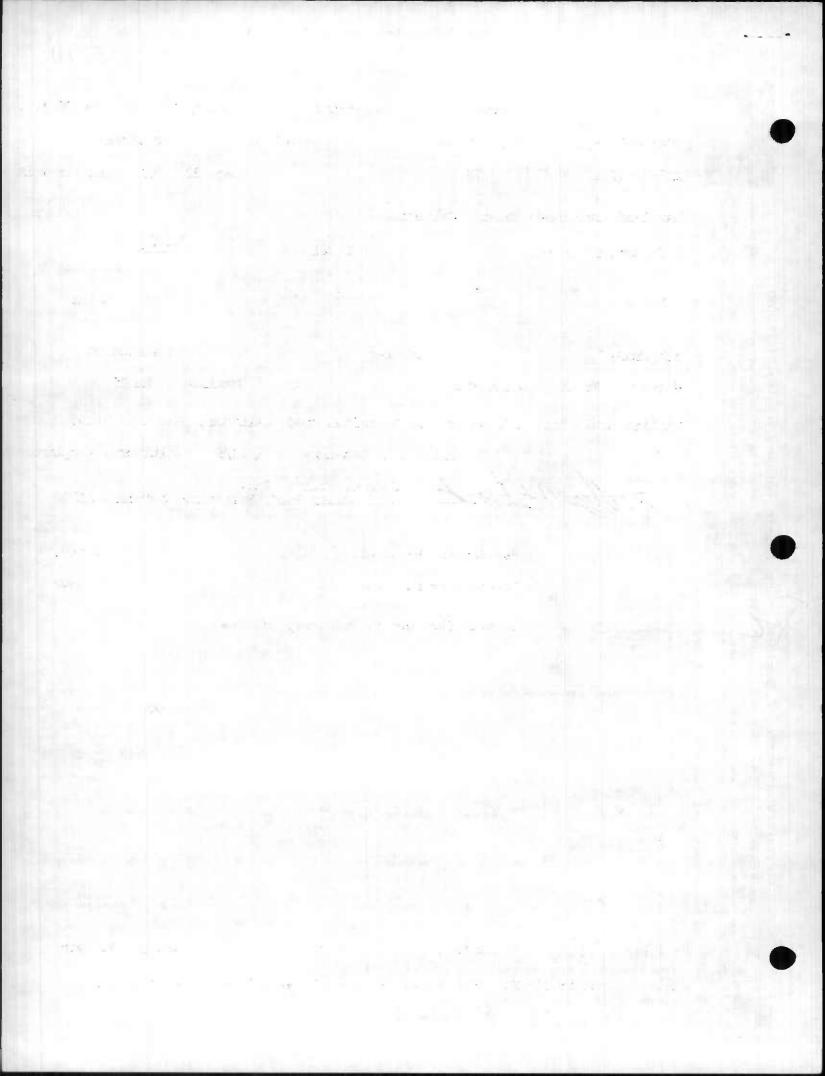
1 ☐ Yes 2 No

28d. Describe how Injury occurred

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

9000 Franklin Square Drive Baltimore Maryland 21237 Dr. Hamilton Small MD.

31. Dete filed (Month, Day, Year) 29 1998 32. Registrer's Signeture Gandaga cha Davidson



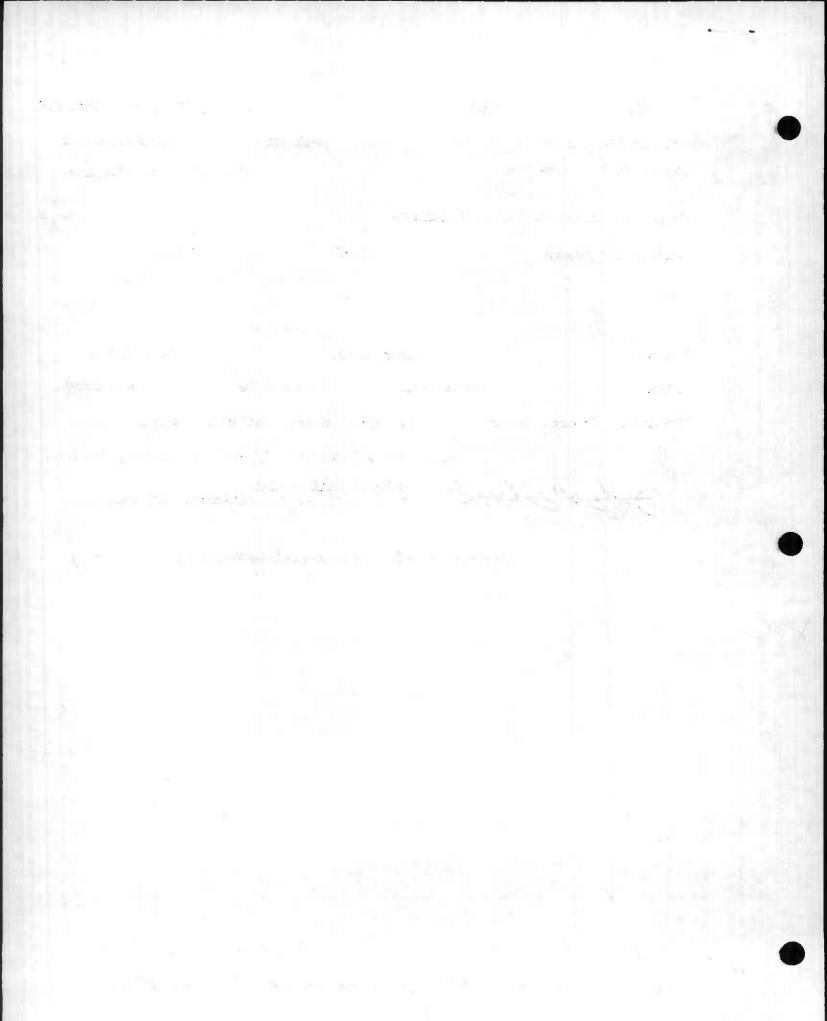
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** January 19, 1998 Month 4:35 P.M. Edward Berrent /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore County Baltimore 4017 Taylor Avenue If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 9. Birthplace (State of Months | Deys | Hours | Min. | Aug. | 24, 1924 | Maryland 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** 15XM 20 F 220-18-5162 Yrs. Director 73 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland Baltimore County Baltimore 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ 4017 Taylor Avenue 21236 U.S.A. items 23s death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married altimore, Maryland 21215-0020 ò 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced "natural", White Completed 15. Decadent's Education 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementery/Secondary (0-12) College (1-4or 5+) Never Worked Never Worked Unknown 17. Father's Neme (First, Middle, Lest) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked otherly hijury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Wisniewski Biedronski Frank Katherine 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Frances H. Roberts/Sister 4017 Taylor Avenue, Baltimore, Maryland 21236 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State Holy Rosary Cemetery 1/22/98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel arteresclante corneryortery desease diseese or condition resulting in death) **Examiner** Due to (or es e consequence of): Physician/Medical Examin Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequenca of): 68760 2 Due to (or as e consequence of): 8 P.O. Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 MUnknown Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Be Completed 24a. Wes en eutopsy performed? page 2 Pes 1 ☐ Yes 2 1 No 1 Yes 2 No Division of Vital certific 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? Attac Attending 5 Pending investigation s after de at Director: Alt 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide ö To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1£ Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted. edicai (Check only 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 21022 1-21-98 Mercu Kewluck us 1 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 8604 HAKFORD AND STORU M> 21234 C. Kurglowsky Ms

62, Registrar's Signeture rung Daydoon—Randall

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** 05 N pm /Medical 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street end number) **Examiner** If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Devs 1□M 2□F Director 091-10-6122 81 1/8/1917 New York Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examine. It was be not indeated. MD 1 ▼Yes 2 No Director N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21214 U.S.A. 6040 Harford Road Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White à 3. Widowed 4 □ Divorced Completed Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Home 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surneme) Be 2 Giuseppe Soffomilie Unknown 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 556 Rivervale Terrace River Vale NJ. 07675 Patricia A. Neary 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore/ Wash. Crematory 1/27/97 Laurel, Md. 22. Name and Address of Fecility Dippel Funeral Home 21. Signature of Funeral Service Licenses 7110 Belair Road Baltimore, Maryland 21206
Do not enter the mode of dying, such es cerdiac or respiretory errest, Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Box 68760, Physician/Medical Due to (or es a consequence of): signad by the e Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. sion of Vital Records, P.O. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed? peen hes 2 100 1 Yes 1 ☐ Yes 2 ☐ No certificate tending Physician: 25. Wes cese referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 1 Yes 2 TM6 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) funeral 27. Menner of Death Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner steted. 29a. Certifier edical (Check only one)

yse of deeth (Item 23a) (Type, Print)

Julia Davidson

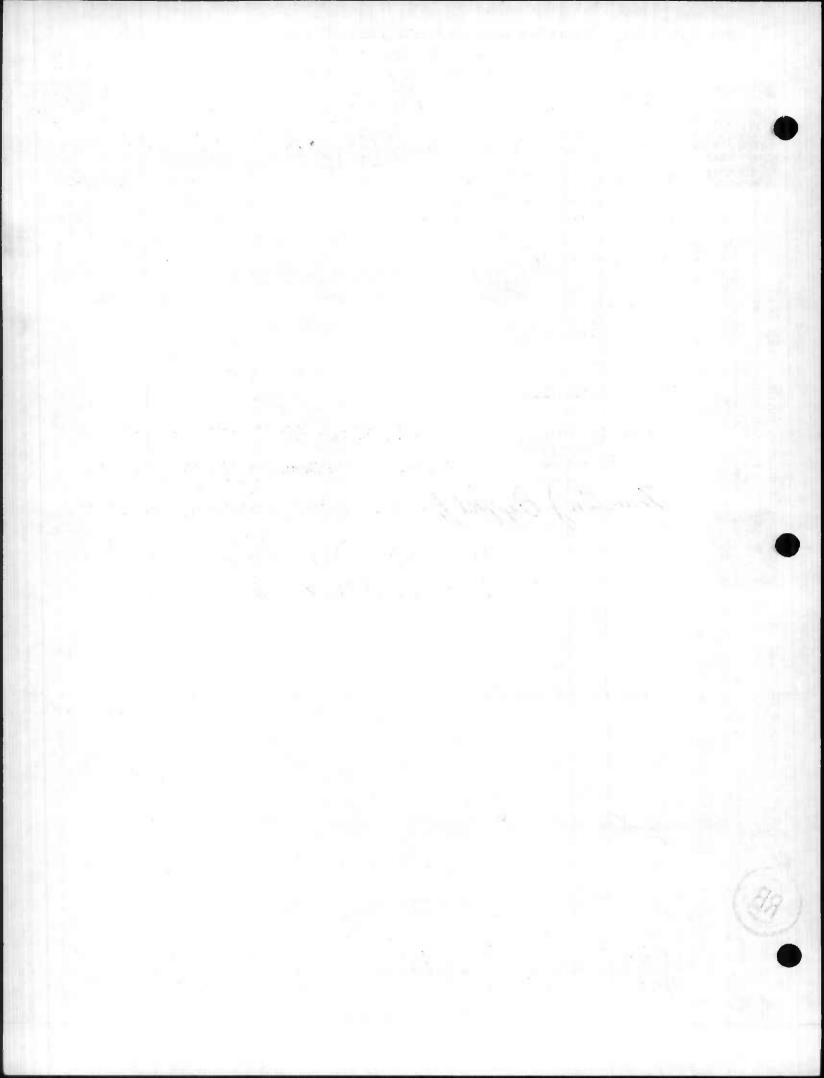
32. Registrar's Signature

29 1998

29d. Dete signed (Month, Dey, Year)

State Registrar 29b. Signature and title of certifier

31. Dete filed (Month, Day, Yeer)



					Cei	rtificate of	Death		Reg. No.		
	Physic		1. Decedent's Name (First, Middle, L.	M. CL	ARI	4		2. Dete of De Month		G G S	3. Time of Death
	/Medi Examii		4e. Facility Name (If not institution, gi		1		4b. City, Town, or L	ocation of Deeth		of Deeth	cpm.
			Church Home Nursi	ing Center			Baltimor	.e.	N	/A	
	Funeral Director		214-40-4548	Sex 7. Age (In yrs. 1	lest birthdey) Yrs.	If Under 1 Year Months Deys	if Under 24 Hrs.	8. Dete of Bir (Month, Da Dec. 8	th y, Year) 1905	9. Birthpl Count Mar	lace (State or Foreign try) Yland
	pur *		Usuel Residence of Decadent 10a. State 10b. County	10c Ci	ty, Town or Lo	cation				4	Od. Inside City Limits
	with the Maryland a or 28a-f show	ō	Maryland N/A	100.00		timore				"	1 ☑ Yes 2 ☐ No
	the M	Directo	10e. Street end Number		buc	10f. Zip Code			10g. Citizen of	Whet Coun	
	th with		8 N. Streeper S	thoot		21224			u. s		
	ee EE	Funerai	11. Marital Status	12. Wes Decedent Ever in U		Was Decedent of	Hispenic Origin? (Sp	pecify Yes or No	- 14. Rac	a - America	
5-0020	a 0 5	þ	1 X Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:		Yes, specify Cut	Specify:	Hican, etc.)		ck, White, e y: Whit	
5-0	72 nat	eted	15. Decedent's E (Specify only highest gr	ducation ede completed)	16e. Deced	lent's Usuel Occu	pation	kina	16b. Kind of B	usiness/Ind	lustry
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	Hygie ther t	ပိ	17. Fether's Name (First, Middle, Las.	4 Years	10	acher	18. Mother's Nam	o /First Middle	Baltim		cty
Maryland	should be filed and Mental Hygis marked other imatic event,	Be C	Richard A. Clark				Augusta		Malderi Surnen	10/	
37	2 shoul and Me is mark	2	19e. Informent's Neme/Relationship		19b. Meilin	a Address (Stree	t end Number or Ru		er. City or Town	State Zin	Code)
Σ			Richard Sellers	(Nephew)			Street,				
ore,	es 1 end of Health I itam 27 r other fr		20a. Method of Disposition	206. [Place of Dispo	sition (Neme of netory or other ple		Dete	20c. Location		
E	Pages net of int: If it		1 🛱 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Themover from State		Cemeter		29/98	Baltimo	re. N	Maryland
Baltimore	permit. Pag Department Important: If any Injury o		21. Signeture of Funeral Servica Lice	nsee / / /	22 S	. Neme and Addre					
	00260		19 but Wa	todout/	3.	331 Breh	ms Lane,	Baltimo.	re, Mari	yland	21213
			23a. Pert1. Enter the disease or con shock, or heart failure. List only	plications that caused the deal one cause on each line.	h. Do not ente	er the mode of dyi	ing, such es cardlac	or respiretory e	rrest,		Approximete Interval Between
	Physician /Medical	П	Immediate Ceuse (Final	00000					100	-	Onset end Death
	Examiner		disease or condition resulting in deeth)	· CEREB.			tr A	-celb	BNI		2 YEARS
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	tificeta be executed ig physician end as the burial-transit	Examiner	Sequentielly list conditions	b. Due to (c	or es e conseq	uence of):					
0	e exe		Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury								
68760,	eta b hysic the bi	edicai	that initiated events resulting in deeth) Lest	C. Due to (c	r es e consequ	uence of):					
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Bo	that the death cer ed by the ettendir datached for use	Physician/									
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of Vital	ilclan: The cartificete ractor, pag	Be C	25. Wes case referred to medical				26. Plece of Deal			0.4	
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	0 60		27. Menner of Death 1 □ Netural 5 □ Pending	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ry et ork?	28d. Describe I	now injury occur	red	71.02.
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- 4	100 P		29a. Certifier 1 Certifying Pt	nysicien: To the best of my kno	wlodgo dooth	accurred at the ti	mo data and place	and due to the	eouse(s) and m		-1
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	To the Hospital or Atte within 24 hours altar de To the Funeral Direct complètely filled in by th	Me	29b. Signeture and title of certifier			29c. Licens			29d. Date signe		
D		E7	1/1. h.	Brem	20	01	7322	2	TAN	26	1998
,	1		30. Name end eddress of person who	completed ceuse of deeth (Iter	n 23e) (Type, I	Print)			2		0.1998
- 1	V		A.R. NAZ	EMI, M.D.	CHO	ned	HOSPITI	AL 1	SALT1	M	0 21231
	Sta		31. Date filed (Month, Dey, Year)	32. Registrar's Signa	ture	0.00			311113		
Ι.	Registr	ar	IAN 291	aca Juke Dr	HOLAMA-R	undalis					

THE RESERVE THE PROPERTY OF STREET WAS ASSESSED.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month January 24, 1998 cetion of Death | 4c. County of Death REV. FRANCIS RICHARD CARMODY, S.J. 5:15 P.M. 4a. Facility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Death WHEELER HOUSE: 3048 Guilford Avenue Baltimore If Under 24 Hrs. Hours Min. If Undar 1 Yaar 5. Social Sacurity Number Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) 1**X**0 M 2□ F Months Days 218-16-1375 Apr. 3, 1923 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Maryland N/A Baltimore City 10e. Street and Number 10g. Citizen of What Country? 3048 Guilford Avenue 21218 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, atc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify 3 ☐ Widowad 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5+ Christian Ministry Jesuit Priest 17. Fathar's Name (First, Middla, Last) William James Carmody Mary DeSales Burke 19b. Malling Address (Street end Numbar or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Typa, Print)

Physician /Medical

Physician

/Medical

Examiner

10a State

Funeral

Director

"netural", or items 23a or 28a-f show

Director

Completed by Funeral

Be

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

7 is marked other than "netur traumatic event, the M of cal

itam 27 i

Depertment of important: If any injury or = 0

Baltimore, Maryland 21215-0020

68760

Records, P.O. Box

Vital

to

Division

Examiner

9,0 After Attending

Physician/Medical by Completed Be

Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 25. Was cese referred to medice! 27. Manner of Death

Certification: To after death Director: To the Hospital within 24 hours a To the Funeral C Medical

Registrar

disease or condition resulting in death) Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

Rev. Mark F. Horak, S.J.

4 ☐ Donation 5 ☐ Other (Spacify)

21. Signature of Funeral Service Universe

1 X Burial 2 Cremation 3 Removal from State

Lawson

20a. Method of Disposition

Immediate Cause (Final

ACUTE CARDIAC ARRHYTHMIA Due to (or as a consequence of):

Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212
23a. Part 1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heer failure. List only one cause on each line.

22. Name end Address of Facility

Mitchell-Wiedefeld Home

Jesuit Cemetery

CARDIO MYOPA 14Y

3048 Guilford Avenue, Baltimore Maryland camatary, cramatory or other place)

CORONARY ARTERY INSUFFICIENCY Due to (or as a consequence of) ATHEROSCLEROSIS

10 YEAAS

Interval Between Onset and Death

IYEAR

3 TEARS

MINUTES

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Wes an autopsy

1/28/98 Woodstock, Maryland

24b. Were autopsy findings available prior to completion of ceuse of death?

1 Yes

1 ☐ Yes 2 ☐ No

26. Plece of Death (Check only ona) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28c. Injury at Work?

28d. Dascribe how Injury occurred 1 ☐ Yas 2 ☐ No

28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stata) Certifying Phyatclan: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and menner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) end manner stated.

290. Spnature and title of certifier

29c. License number D07316 29d. Date signed (Month, Day, Yaer) TAN - 26

23b. Dld tobacco use contribute to the cause of death?

ie and address of person who completed cause of death (nem 23e) (Type, Print) eleph D. NOTARANGELA

MJ. 301 ST. PAUL PLACE - BALTIMONE MD 21202

31. Data filed (Month, Day, Yaar) JAN 29 1998

examiner? 1D Yes 2 No

5 Pending

Investigation

6 Could not be

Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

32. Registrar's Signature in audson-handelle

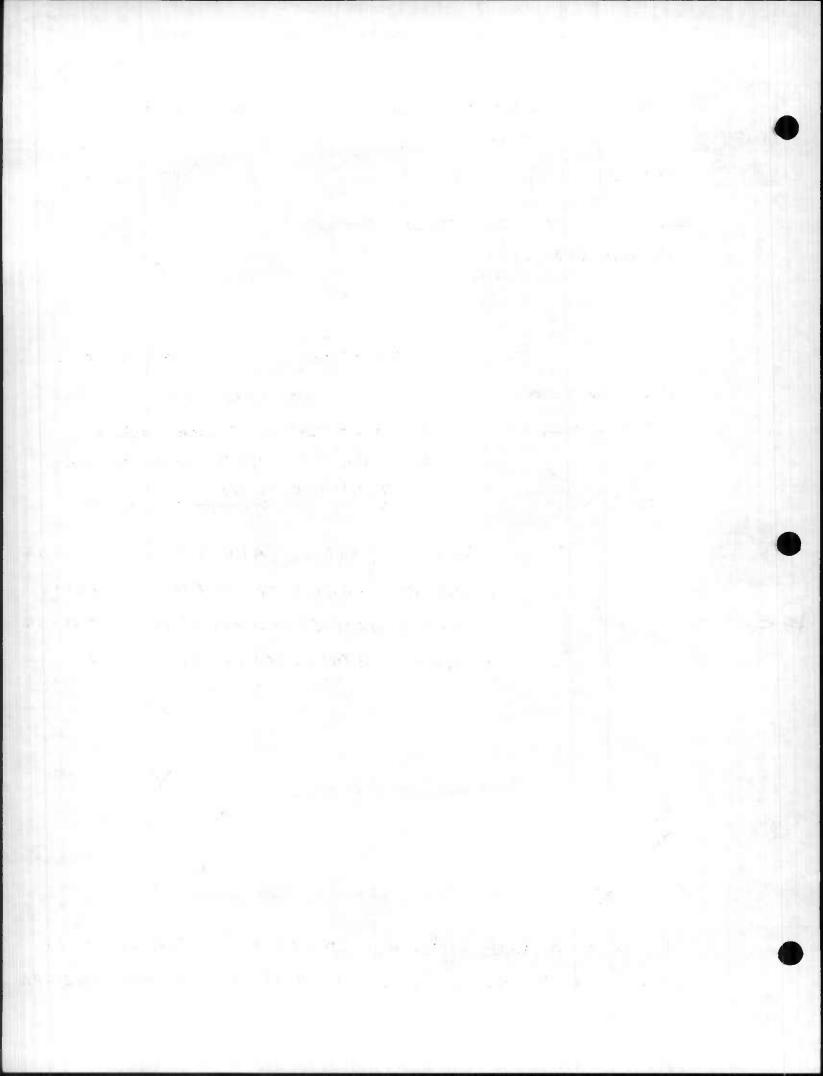
CORONARY

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

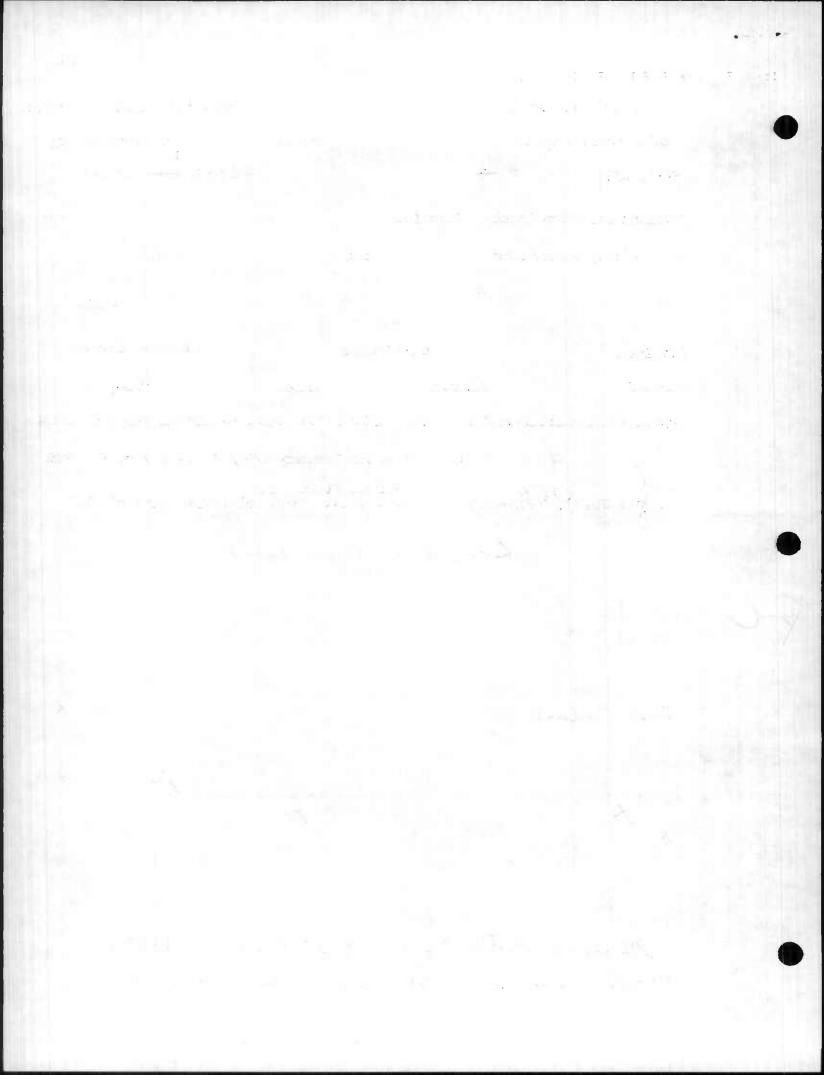
28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Date of fnjury (Month, Day Year)



		er FH Film G-755 1-2					of Death			Reg. N	20	0 2	170
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Medica	al -	Mary NMN Cunn							Januar		5, 19		9:40 P
xamine	er	4a. Facility Nama (If not institution,)					ocation of Daar		c. County		
	М,	Stella Maris Ho	-			Kilindas 1 Va	Timon			В	altin		County
neral ector		086-07-8522	7. As	ga (In yrs. 1	last birthday) Yrs.	If Under 1 Ye Months Da	ys Hours	Min.	8. Data of Bi (Month, Di July 1(rth ay, Year), 1	909	9. Birthpl Count Irel	aca (Stata or Fo ry) and
	-	Usual Rasidanca of Dacadant 10a. Stata 10b. County		10c. City	y, Town or Loc	ation						10	Od. Insida City Li
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4	<u>a</u>	2300 Dulaney Val	lev Poad			21093					.S.A.		ry:
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3	by Fur	1 Never Marriad 2 Married 3 Widowad 4 Divorced	Armed Forcas		lf	Yes, specify C	Cuben, Maxicar	n, Puarto	Rican, atc.)			k, Whita, a	
edical	De l	15. Decedant's	Education		16a. Deceda	ant's Usual Oc	cupation		.4.	16b. I	Kind of Bu	siness/Ind	ustry
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the M	E C	6th Grade	College (1-40)	34)	Line V	Worker				Defense Compan			pany
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traumatic		19a. Informant's Name/Ralationship	(Type, Print)		19b. Mailing	Addrass (Str	eet and Numbe	er or Run	al Routa Numb	er, City	or Town,	Stata, Zip	Coda)
igury or other		Reverend John Cu	nningham/So	on	6806 1	McClean	Boule	vard	, Balti	mor	e, Ma	ryla	nd 21234
		20a. Mathod of Disposition	37	20b. P	laca of Dispos ematary, cram	ition (Nama of atory or other	f place)		Data	20c. i	ocation -	City or Tox	vn, Stata
		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spa		1	ate of Heaven Cemetery 1/30/98 Hawthorne, New Yo							ew York	
		21. Signature of Funaral Sarvica Lic	cansaa	1	22.	Nama and Ad	Idrass of Facili	ty		-			
any ir		John C. Miller, Inc.											03.006
		231 Part Inter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, in the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, in the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, in the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and the death of the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and the death of the disease, or complications the death.											Z1ZU6 Approximeta
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naktranan	Examine	Sequantially list conditions, if any, laading to immadiate cause. Entar Underlying Causa (Disaasa or Injury	b	Dua to (or	r as a consequ	ience of):							
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Lillian May Corkran January 24, 1998 1:30 P.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Ivy Hall Nursing Home Middle River Baltimore County 8. Date of Birth (Month, Day, Year) Dec. 22, 1915 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F Days 212-28-9963 Yrs. Director Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 XNo Director Maryland Baltimore County Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 1 Brett Court, #328 21221 U.S.A. items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. event, the Medical Examiner. 72 hours after 1 Never Married 2 Married ŏ 1 Yes 2X No Specify: Specify: by 3 Widowed 4 □ Divorced "natural", White Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiena. marked other than Elementery/Secondary (0-12) College (1-4or 5+) Homemaker 10th Grade Own Home Tis merk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Mech Carrie Harman 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Haaith e If item 27 ia or other tran Linda Hilda Vykol/Daughter 6420 Rosemont Avenue, Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any Injury or once. Holly Hill Cemetery 1/28/98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer / Service Licensee 22, Name and Address of Facility
John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 23a. Part . Enter the isease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Arute CVA disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai 2 Due to (or es e consequence of) that the death certificate ettending p signed by the e Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 2q 24a. Was an autopsy performed? 24b. Were autopsy findings evailable prior to Completed completion of ceuse of deeth? paga 2 has 1 Yes 2 2 No cartificate 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending 1 Maturai 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred af the time, date and place, end due to the ceuse(s) and menner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, end due to the ceuse(s) and manner stated. edical 29a. Certifier

Records, Division of Vital Hospital or Attending Physician: 24 hours aftar death.
Funeral Director: After this cartificately filled in by the funaral director, I To the Hospital within 24 hours a To the Funeral Completely filled

Baltimore, Maryland 21215-0020

P.O. Box 68760

Registrar

29b. Signeture and title of certifier

· HROWI 22 82 Registrer's Signature rung Jawason-Randall

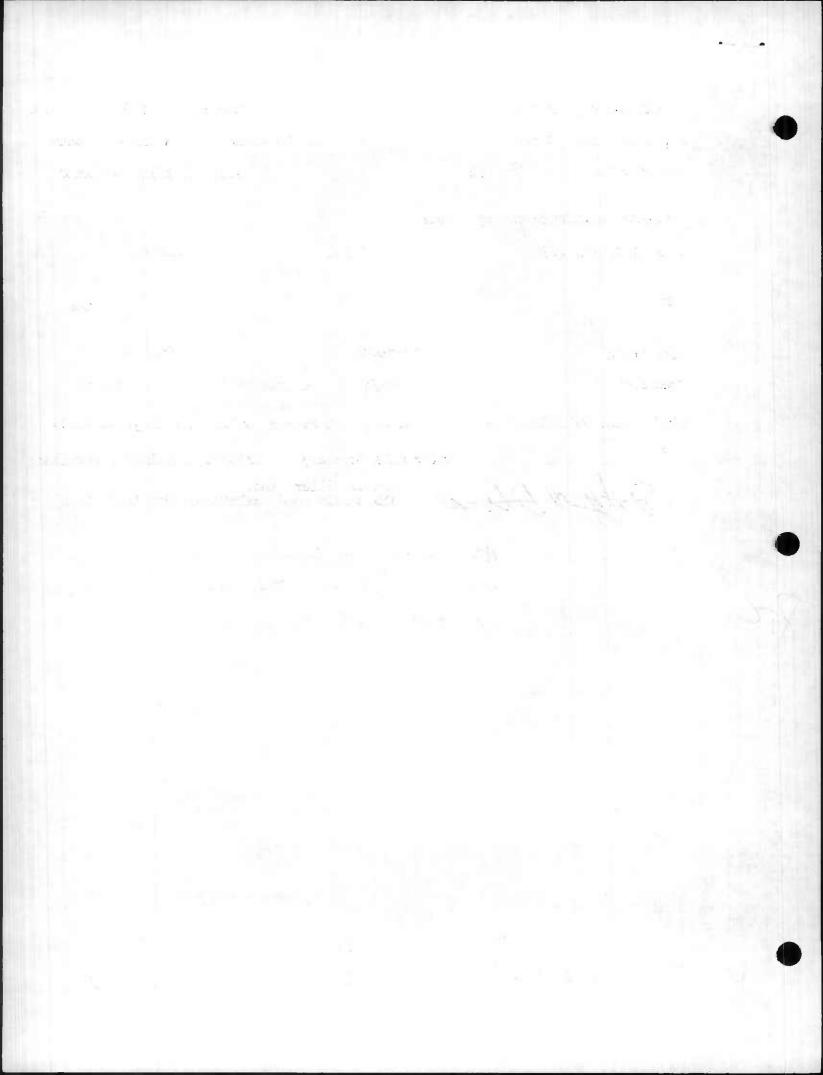
30. Name and address of person who completed cause of death (item 23a) (Type, Print)

29c. License number

14221

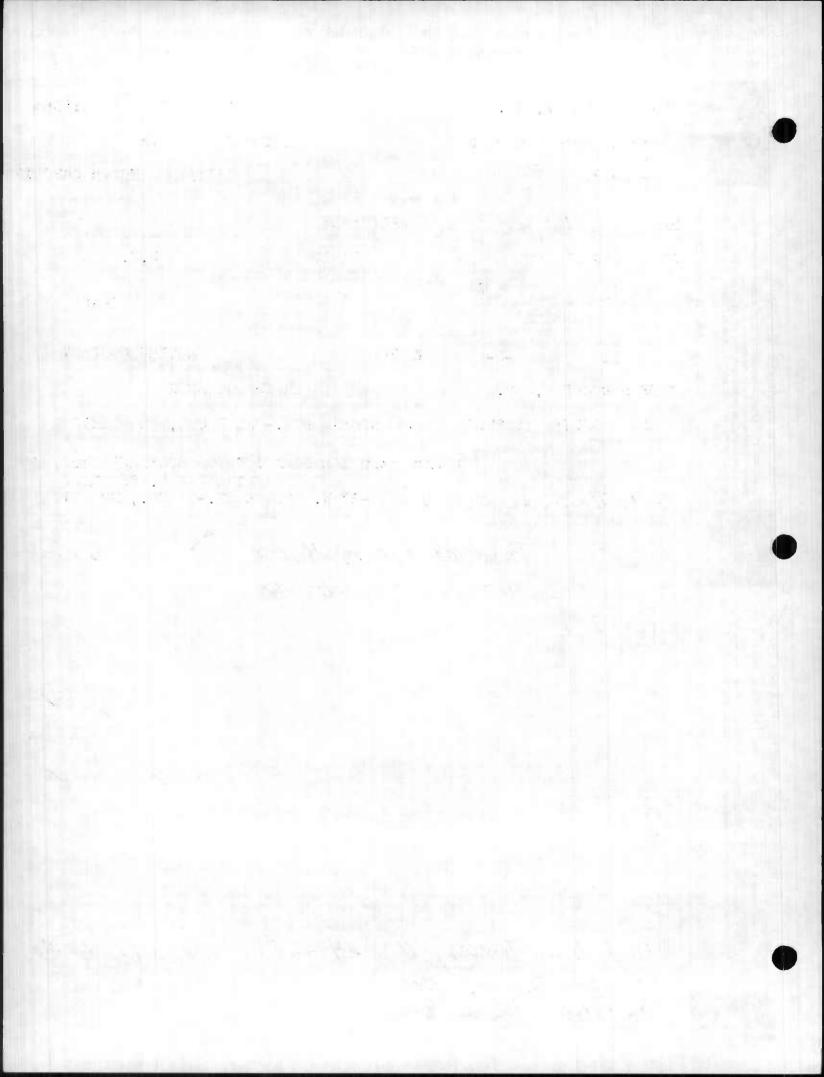
29d. Date signed (Month, Day, Year)

BALT mg 2/22/



State of Maryland / Department of Health and Mental Hygien € Ω Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** 98 JOSEPH DOGGETT, JR. 4:55pm /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner BALTIMORE LIBERTY MEDICAL CENTER N/A 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 15 M 2 F Months Days Yrs. Director 44 NORTH CAROLINA 240-88-8293 Usual Residence of Decedent with the Meryland 10d. Inside City Limits 10e State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1 X Yes 2 No Director N/ABALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21217 612 BAKER STREET U.S. Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer of Deperment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or hen any injury or other traumatic event, the Medical Examine page. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 🎝 ☐ No Specify: by 3 Widowed 4X Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) MOVER MOVING COMPANY 11 -0-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPH DOGGETT, SR. SHIRLENE JOHNSON 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MINNIE HOPKINS (SISTER) 3403 ROGERS AVE.-BALTIMORE, MD 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 🕍 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STATON MEMORIAL PARK 1/28/98 SCOTLAND NECK, NC 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ELIZABETH L. PHILLIPS 1721-27 N. MONROE ST.-BALTO., MD 21217 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records. þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was en eutopsy performed? hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No • Hospital or Attending Physician: 24 hours after deeth. • Funeral Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Ves 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 | Inpatient 2 | ER/Oufpetient 3 | DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 27. Manger of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturel 2 🗆 No 2 ☐ Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end fitte of certifier 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 29 1998 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Daeth 3. Tima of Death Month . Flov Dorman. 0300 301 St. Paul St. 4a Facility Nama (fr not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Medical Balt. If Under 24 Hrs. Mercy enter 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Min. 37 1DM 2DF Months Deys none Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Himore 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? USA Wind 21244 Circle 5 12. Wes Decedent Ever In U.S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Datas: 13. Wes Decedant of Hispanic Origin? (Specity Yas or No-If Yas, specity Cuban, Mexicen, Puarto Ricen, atc.) 14. Race - Amaricen Indian, Black, Whita, etc. 1® Never Married 2□ Married 1 Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decadant's Education (Specify only highast grada complated) College (1-4or 5+) Elementery/Secondary (0-12) none none 18. Mothar's Nama (First, Middla, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Dorman heodore Barbara 19a. Informant's Nama/Ralationship (Typa, Print) 19b. Mailing Address (Streat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda) Barbara Clark 54 West nds ircle ern 20b. Placa of Disposition (Nama of cematery, cramatory or other place, 20c. Location - City or Town, Stete 20a. Method of Disposition Data 1 ☐ Burjai 2 ☐ Crametion 3 ☐ Ramovai from Stata 4 Donation_5 □ Othar (Specify) 21. Signatura of Fundral Savins Licensea Renal Joy So Wade, Director StarpanAffersom FacilBoard, 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, sheck, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Finel disaasa or condition resulting in death) Dua to (or as a consequence of): Sequantially list conditions, if any, laading to immediate ceusa. Enter Undarfying Causa (Disaase or injury that initiated avents rasulting in daath) Last Dua to (or as a consequence of) Due to (or as e consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 1 Yes 24 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yas 2₽No 1 □ Yes 2 □ No 25. Was cesa referred to medical axaminar? 26. Pieca of Daath (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA

28d. Describe how injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29d. Data signed (Month, Day, Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Saltimore, Maryland 21215-0020

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raquires that the daath cartificete be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: To the Hospital or Attendir within 24 hours eftar death. To the Funeral Director: Af

Registrar

Medical

31. Dete filed (Month, Day, Year) 29 1998

27. Mannar of Daath

1 Natural

2 Accident

3 ☐ Suicide

29a. Cartifia

4 - Homicida

(Check only one) 29b. Signature

30. Name and add

5 Panding Invastigation

6 Could not be detarmined

indser 32 Bon strar's Signatura rdia laydon Randoll

the completed ceuse of death (Item 23e) (Type, Print)

28a. Data of Injury (Month, Day Year)

28b. Time of

28a. Place of Injury - At homa, farm, straet, fectory, office building, atc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To tha bast of my knowledge, deeth occurred at tha tima, deta and plece, end due to tha ceusa(s) and menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and manner stetad.

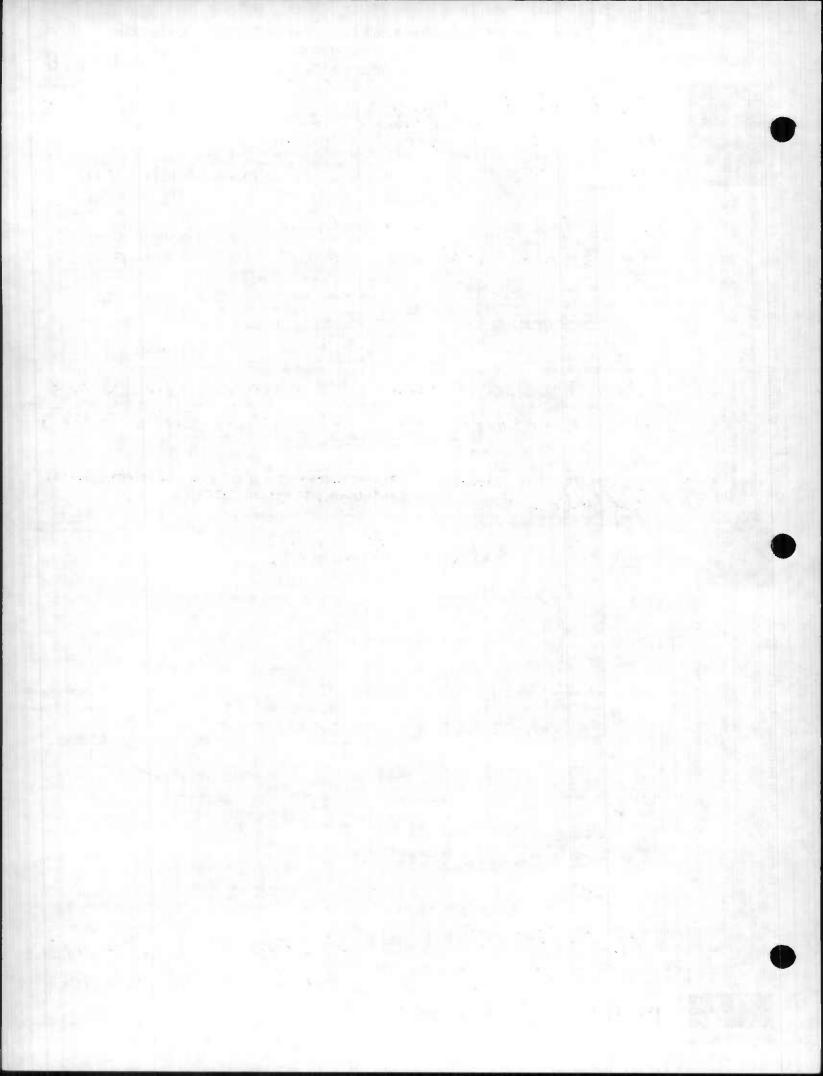
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

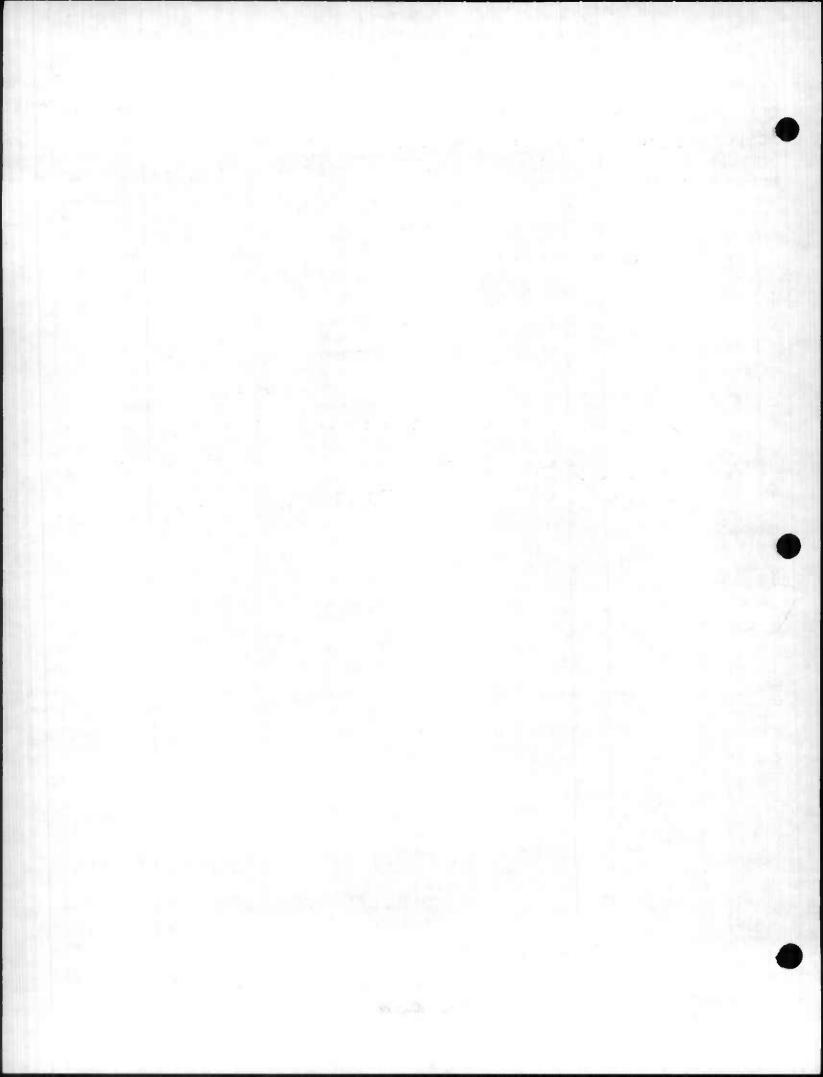
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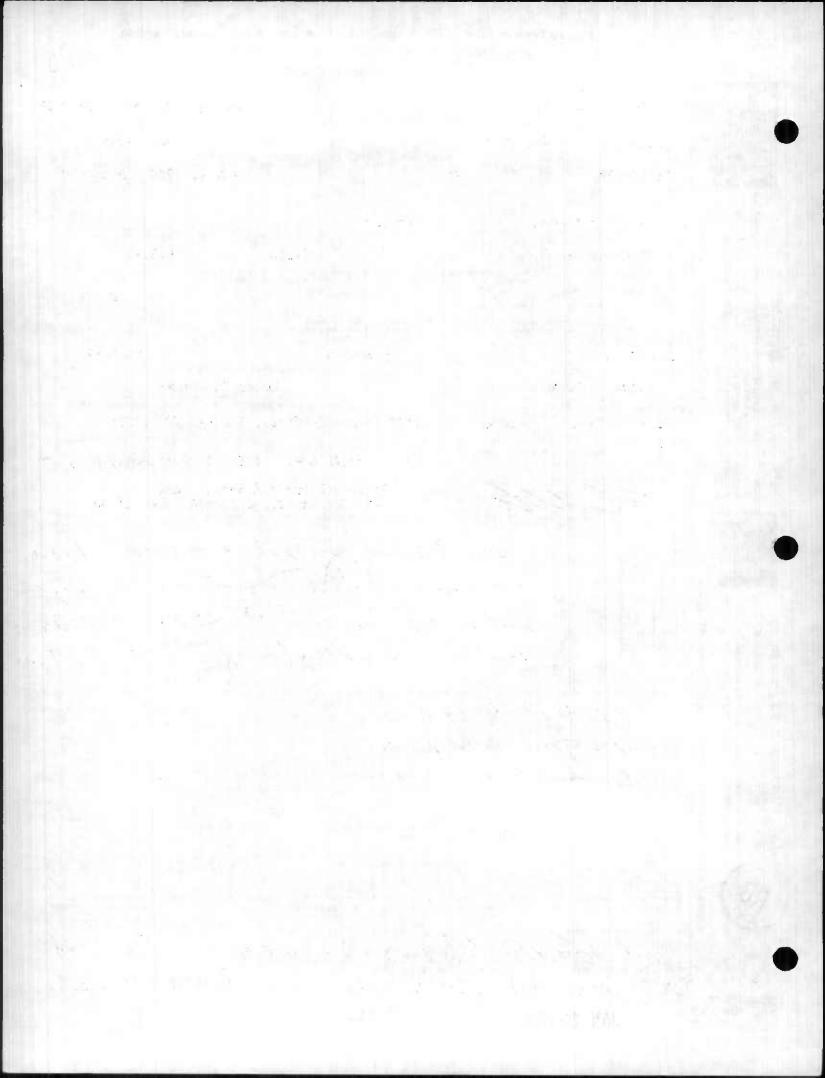
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State of Maryland / Department of Health and Mental Hygiene

			C	ertificate of	Death	R	eg. No.	02180
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or 28a-f st be notified Director	10e. Street and Number	LE	10	10f. Zip Coda			0g. Citizan of What	Country?
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ural, or items 23a il Examiner must id by Funeral	11. Marital Status 1 □ Navar Marriad 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedant I Armed Forces? 1 ☐ Yas 2 ☐ N If Yas, Give Yaar or Datas:		3. Was Dacedant of If Yas, specify Cub 1 ☐ Yas 2 💢 No	Hispanic Origin? (Span, Maxican, Puarto o Spacify:	pecify Yes or No- Ricen, atc.)		maricen Indian, Thite, atc. White
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1/2-200-	DR. 1111Chael	MIE VE	350 W	Hiner	STUR	DAC	10 146	01200
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificular be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending introduce and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiens and to be a completely filled in the next be notified at once.

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	-niir	ICAL	- 01	DEA	П		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) MARY CHRISTINE EI	NGEL							JAN.	25 DA	19	98"	3. TIME OF DEATH 4:40 A M
	4. SOCIAL SECURITY NUMBER 261–21–6010	5. SEX 1 M 2 XX	6. AGE (In yrs. less	t birthday) YRS.	IF UNDE	DAYS	HOURS	MIN.	7. DATE OF (Month, E)	26, 1	1914		PLACE (State or Foreign YORK
LOR	9a. FACILITY NAME (If not institution, give a MARIA HEALTH CARE RESIDENCE OF DECEDENT		INC.			TOWN	RE	ON OF D	EATH			IMOR	
DIRECTOR	10a. STATE 10b. COUNT BALTI	MORE		BA	LTIM	OR LOCA	TION						10d. INSIDE CITY LIMITS? 1 YES 2 X NO
FUNERAL	6401 N. CHARLES	ST.					1. ZIP COD 2121				USA		HAT COUNTRY?
BY FUN	11. MARITAL STATUS XX Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 (IF YES, GIVE W	YES 200		13.	If yea, ap		ın, Maxicı	NIC ORIGIN? (an, Puerto Ric fy:		or No-	14. RACE Black Specifi	— American Indian, , White, atc. by: WHITE
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		(G.	ive kind of	ise retired.)	during me	ON ost of worki	ng		MENT			LS
ш	17. FATHER'S NAME (First, Middle, Last) HENRY ENGEL								EICHH		Surname)		
TO B	196. INFORMANT'S NAME (Type/Print) BERNICE FEILINGE	R	6	MAJLIN 401	N. C	s (Street HARL	ES S	r or Rural P. B	ALTO.	MD Company	n, Stete, Zip 21212	Code)	
	20s METHOD OF DISPOSITION ABurial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	noval from State	20b. PLACE of cometery, cre VILL					1	-27-98		CATION		
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	20_				ELL			HOME	6500	YOF	K RD 21212
	23. PART I. Enter the diseases, or ahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death)		e on each line	b.						c or reapi	ratory an	eat,	Approximete interval Between Onset and Death
CERTIFICATION	Sequantially list conditions, if sry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. Col	AL FIB OR AS A CONSE OR AS A CONSE	DUENCE (OF): EXTER		Oise	A80	E .				
EDICAL C	PART II. Other significant condition	ns contributing to	death but not i	resulting	In the u	nderlylr	ng cause	given in		4a. WAS AN PERFO	RMED?	24b	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
AN: M	DID TOBACCO USE CONT	RIBUTE TO CA			ES ATH (Check			CERTAI	N 🗆				T TES 2 NO
SICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHE	R:		lasidanca	6 🗆 Other (Specifyl			
Y PHYSICIAN:	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF (Month, Da	INJURY	28b. TI		28c. IN	JURY AT ORK? YES 2		28d. DESC		NJURY OC	CURED	
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarmined	28e. PLACE Of building,	F INJURY — At ho	oma, farm	, atreet, fa	ctory, offi	ce			ION (Street Town, State,		r or Rural F	Route Number,
COMPLET	29e. CERTIFIER (Check only one) t CERTIFYING PHYS												a) and manner as steted.
8	296. SIGNATURE AND TITLE OF CERTIFIE	ER CHO					Do		2316		•	124	(Month, Day, Year)
10	30. NAME AND ADDRESS OF PERSON W	CCH M.C	D. 65	65 (F)	oe, Print)	CH			T, V	ðωsα)N	HO	21204
	JAN 2.9 1998	Scha Day	R'S SIGNATURE	se.									

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 26, 7:00 P.M. Mildred Gray

4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore Randallstown Genesis Nursing Home 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1-1-1917 Months Deys 1□ M 2⊠ F Hours Yrs 80 Va 212-14-2291 Usual Residence of Decedent 10d. Inside City Limits 10e. State 10h County 10c. City. Town or Location 1 Ves 2 No N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 21215 3813 Lewin Avenue 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) N/A College (1-4or 5+) Elementery/Secondery (0-12) At Once Cleaning Service Janitor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Baltimore, Md 21215 3813 Lewin Avenue Rosa Reese - God Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1☐Burial 2☐Cremation 3☐Removal from Stete 4☐Donation 5☐Other (Specify) Voshell Memorial Garden 1-28-98 Baltimore, Md 22. Name and Address of Fecility March F/H West 21. Signeture of Furneral Service Licensee Baltimore, Md 21215 4300 Wabash Avenue 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting In death) Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 30 No 3 Probably 4 Unknown 1 Yas 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy

Physician /Medical Examiner

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24 To the 7 within 2 To the 1

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Division of Vital Records, P.O. Box 68760,

Examine

Physician/Medical

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Completed

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Certification:

Medical

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinal must be notified an once.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

26. Place of Death (Check only one)

28d. Describe how Injury occurred

25. Was cese referred to medical examiner? 1 Yes 2 No	Но	spital: 1 Inpatient 2	☐ ER/Outpetient	3□
7. Manner of Deeth 1 Naturel 5 ☐ Pending investigation		28a. Date of Injury (Month, Day Year)		М

28c. Injury et Work? 1 ☐ Yes 2 No 28e. Place of Injury - Al home, farm, street, fectory, office building, etc. (Specify)

Julia Davidson

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

2 Accident

3 Suicide

4 T Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and manner stated.

DOA

29b. Signature end title of certifie

6 ☐ Could not be

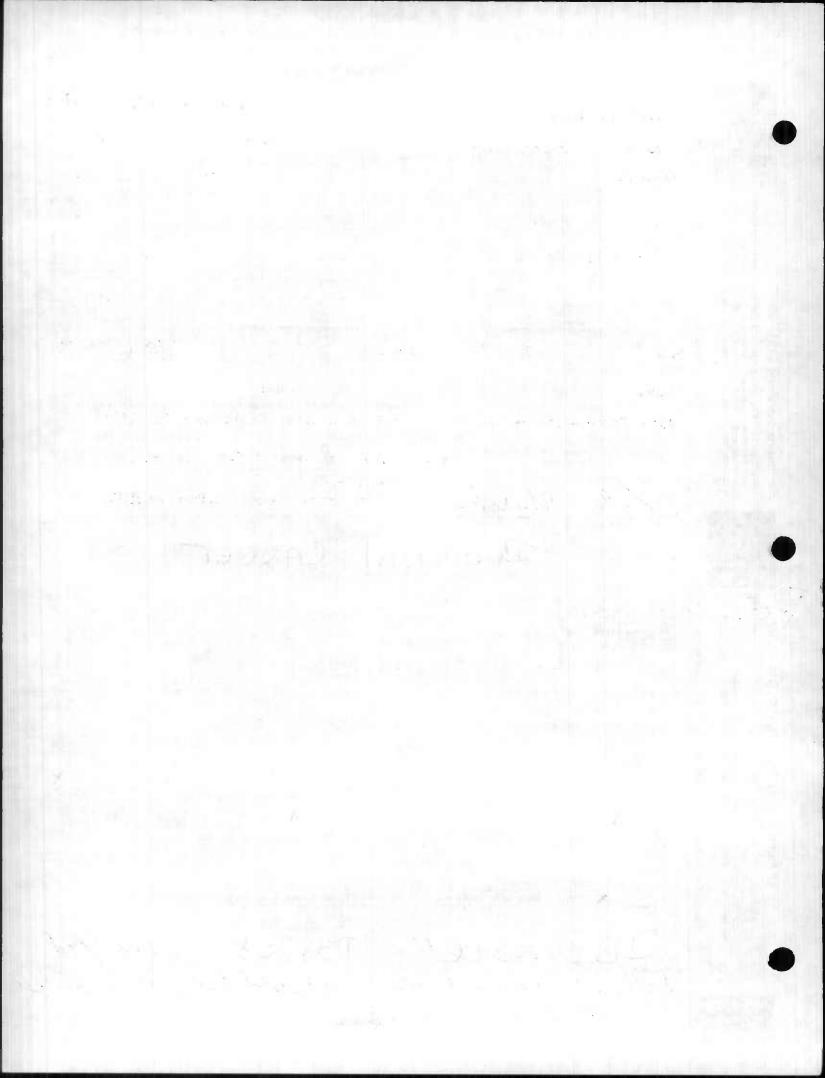
29c. License number

23e) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

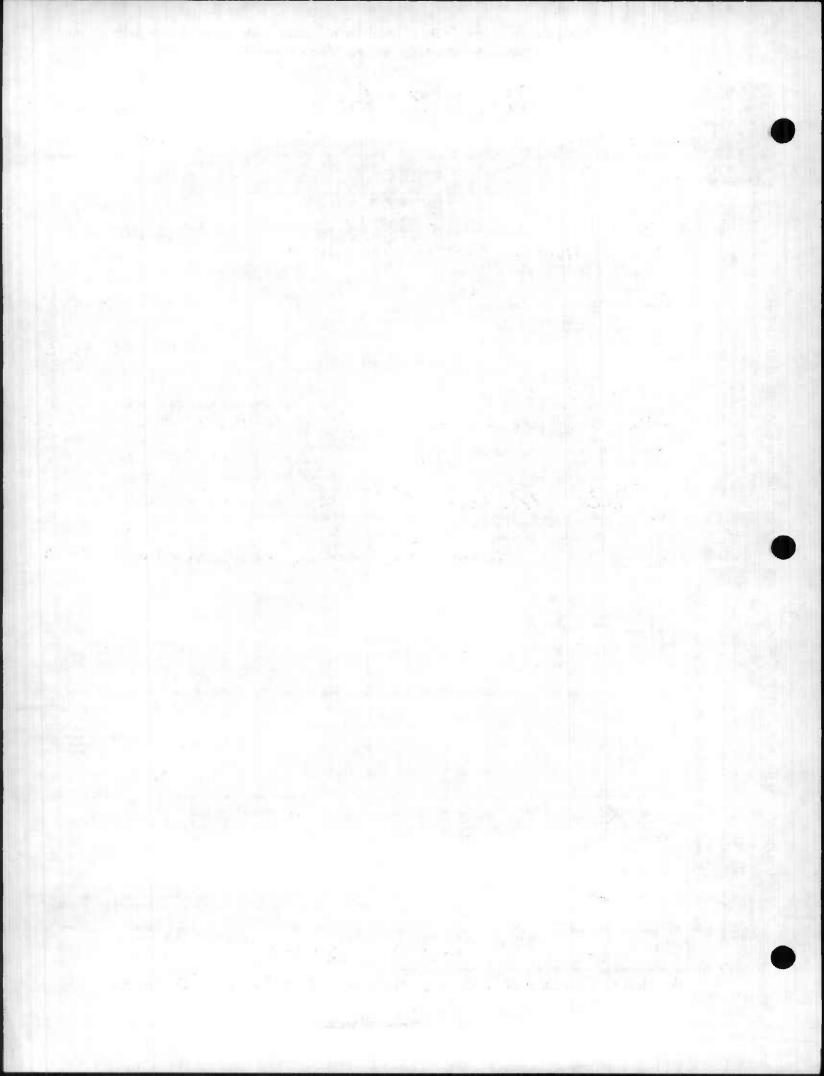
29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	Decedent's Neme (First, Middle, Last	01 0	Certificate of	of Death	2. Dete of Dec		3. Time of Deeth
Physician /Medical		Illinnie 1	C. Gili	nore	Month	124,19	98 8.59A
xaminer	4a Facility Neme (If not institution, give	street end number)		4b. City, Town, or L	ocation of Deeth	4c. County of	Deeth
neral	Man Dr Care 5. Sociel Security Number 6. S		birthday) If Under 1 You Months Da	FOWSOY BOAT If Under 24 Hrs. BAYS Hours Min.	8. Dete of Birt (Month, De		Birthplace (State or Forei
tor	215-28-2709 1 Usuei Residence of Decedent	□M 2 19 F 65	Yrs.	7000	7-16-1	932	Mq
by Funeral Director	10a. Stete 10b. County		own or Location				10d. Inside City Limit
ecto	10e. Street end Number	A DO	2 (timbre	do.		10g. Citizen of Wh	1/2 Yes 2□N
Funeral Director	605 N. Hon	roe Street		21217		U	S.A.
ner	11. Marital Status	12. Wes Decedent Ever in U,S. Armed Forces?	13. Was Decedent If Yes, specify (of Hispenic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race Bieck	American Indien, White, etc.
by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates:	1 □ Yes 2 🔼	No Specify:		Specify:	Black
eted	15. Decedent's Ec	ucation 1	6e. Decedent's Usuel Oc (Give kind of work do	ecupation one during most of work	sina	16b. Kind of Bus	ness/Industry
Completed	Elementery/Secondery (0-12)	College (1-4or 5+)	life DO NOT use re	one during most of work		Privas	te Home
Be Co	UNKADWA 17. Father's Neme (First, Middle, Last)	70	Dones	18. Mother's Nam	e (First, Middle,	Maiden Sumame)
To	Jarus Gilmi	re		Mable	Mack		
	19a. Informent's Neme/Reletionship (11	19b. Mailing Address (St.	reet end Number or Ru	Pel Route Number	er, City or Town, S	tete, Zip Code) 2/2
	20e. Method of Disposition	00.00	e of Disposition (Neme of etery, cremetory or other	f plecen	Dete	20c. Location - C	ity or Town, Stete
	1 Burial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specify	Hemover from Stete	sutus Mer	1 Park 1	-29-98	Arbut	us, red
- Suce	21. Signeture of Funerel Service Licen	see .	22. Name end A	ddress of Fecility W	st,	1	2/2/3
	23a. Parti. Enter the disease, or com	Dications that caused the death I	On not enter the mode of	1300 Was	or respiretory e	great.	Baltu, Kel
	shock, or heart feilure. List only	one ceuse on each line.					Approximete Intervel Between Onset end Deeth
н	Immediate Ceuse (Finel disease or condition resulting in deeth)	· Vancea	the Care	mana me	tustati	c 40/1/08	- 2 mes
وَ ا		Due to (or es	a consequence of):				
Examiner	Sequentially list conditions,	b. Due to (or es	e consequence of):				
	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events	c					
fedicai	resulting in death) Lest	Due to (or es	e consequence of);				
ian		d					
Physician/M	Pert II. Other significant conditions of	ontributing to death but not resulting	g in the underlying cause	e given in Pert I.		.1	ribute to the cause of deat
by Pt					1 🗆	Yes 214No	3 Probably 4 Unkno
ted						en eutopsy med?	24b. Were eutopsy finding eveilable prior to completion of cause
Completed							of deeth?
6)	25. Wes case referred to medical			26. Place of Dee	th (Check only)		1 ☐ Yes 2 ☐ No
To B	exeminer? 1 ☐ Yes 2 ZNo	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient 3□ DOA			dence 6 □Othe	(Specify)
	27. Menner of Deeth Naturet 5 Pending	(Month, Dey Year)		Injury et Work?	28d. Describe	how injury occurre	d
Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home	M , farm, street, fectory, of	1 ☐ Yes 2 ☐ No			r or Rural Route Number,
Certi	4 Homicide	building, etc. (Specify)			City or To	wn, Stete)	
edicai	(Check only 2 Medical Exam	valcian: To the best of my knowled inar: On the basis of examination					
Med	one) 29b. Signeture end title of certifier	end menner stated.	29c. Li	cense number		29d. Date signed	(Month, Dey, Yeer)
	1 Harra	Talentelle	a am	28127		1/28	198
		completed cause of deeth (Item 23	Se) (Type, Print)	01.10-	11 05	> 2.0-	
*****	Howard S. Free a	nd, M.D. 5601 L 32. Registrer's Signeture		n Blvd., Ba	Ho, M	D 9193	59
State	JAN 2	9 1998 - 48: 1	widow Bando				

DHMH 16 Rav 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Amended #28a-c per Phy G755 1/27/98 EW 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month ^{/ear} 98 **Physician** 16:37pm Gilliam Jan. 11 Johnnie /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05-04-32 Birthplaca (State or Foreign Country) 6 Sev **Funeral** Months 1₽M 2□ F Days Hours 65 Yrs. Director 250-46-7511 SC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County must be notified at 1∏Yes 2∏No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 2223 Barclay Street 21218 USA Funeral deeth 12. Was Decedent Ever in U,S.
Armed Forcas?
1 ☐ Yas 2☐ No
If Yes, Give
Yaar or Dates: tems Was Dacadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after of Departmant of Heelth end Mental Hygiena. Introvant: if Item 27 is merked other than "natural", or item only injury or other treumetic event. treumetic event, the Medical Examiner. 1 Navar Marriad 2 Married 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Potts & Callahan 10th Grade Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middla, Last) To Charlie Suber Mattie Gilliam 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 2223Barclay Street Baltimore, Maryland Arleen Gilliam Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem.Pk. Cem. 01-17-98 Randallstown, Md. 22. Name and Address of Facility 21. Signature of Funeral Sarvice Licenses Baltimore, Maryland 21202 NMO WM.C. March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) distanting Hours mgo CARDIA Examiner Examiner ARTERNOSELERUSES 10 425 Coposepps physician end s the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that Initiated avants resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequenca of): esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown HEAR Division of Vital Records. p 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed hes 1 □ Yas 25 No WITH DYSPARGA (3 yrs) 1 Yes GLD CEREBRO USSWERE or Attending Physician: eftar deeth. Director: Aftar this certific 25. Was case referred to medical axaminer?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) To Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending Investigation 28e. Placa of thjury - At home, farm, street, factory, office building, etc. (Specify) 1 Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 4 - Homlcide Mospital 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. License number Thero 9 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

PERMSYLVAMIA

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32. As Shapp Randell

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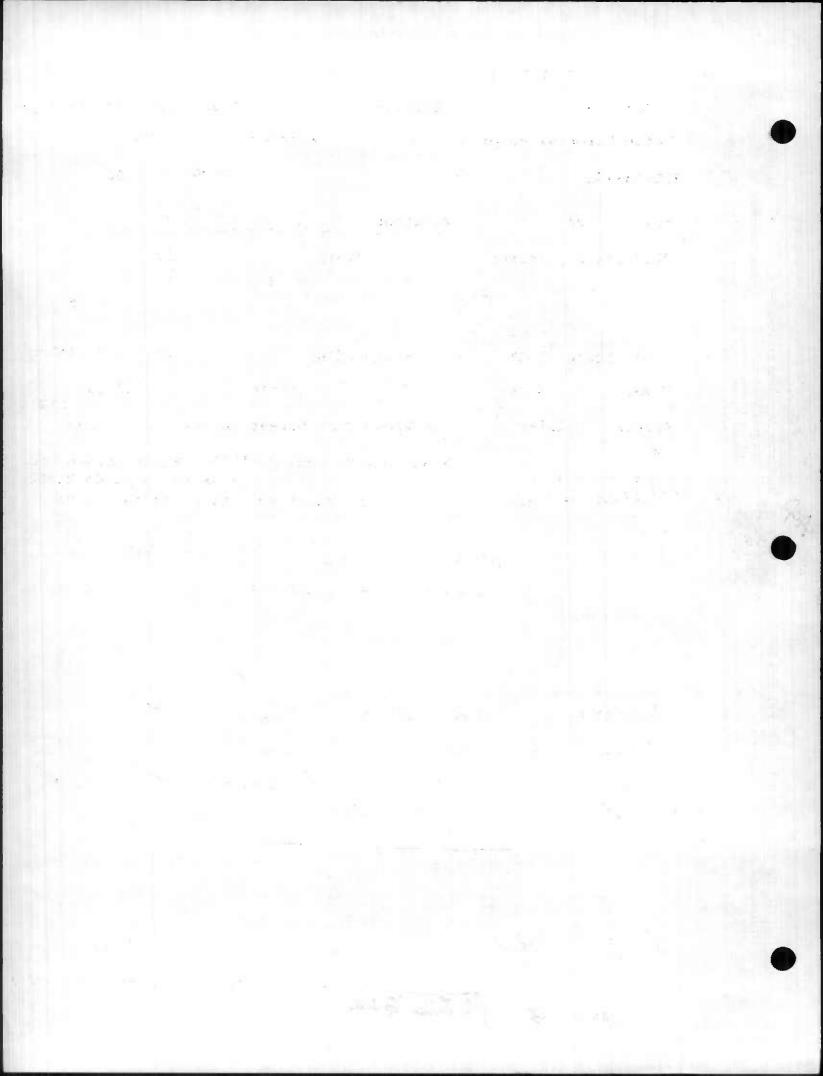
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31. Date filed (Month, Day, Year)

BOLTI MORE WD 21217

Registrar **DHMH 16 Rev 6/95**

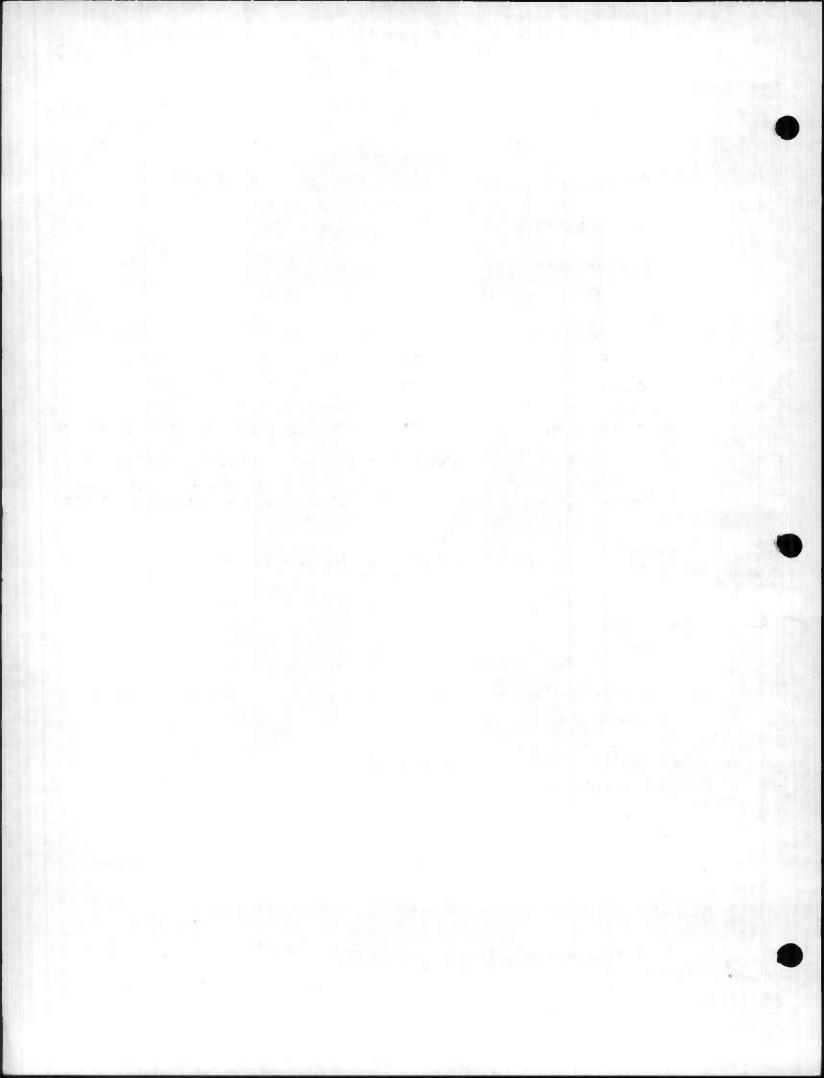
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State of Maryland / Department of Health and Mental Hygiene 5 5 5

	_				Certilic	ate of	Death	Reg	, No.		
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/Medical	L	BERNARD				GEHE		JAN. 25	1998	4:	43 PM
Examiner	4	e. Fecility Neme (If not institution, g.	ive street end number)				4b. City, Town, o	Location of Death	4c. County of	of Deeth	
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uneral	5	Social Security Number 6.	Sex 7. Ag	e (In yrs. last b	Mont	nder 1 Year ths Deys			(eer)	9. Birthplece (Stete or Foreign
rector	1	125-26-5086 Isual Residence of Decedent	MAD WI ZOI	77	Yrs.			OCT. 20),1920		RUSSIA
Mon H	1	0e. Stete 10b. County		10c. City, To	wn or Location					10d. In	side City Limits
Director		MD BAT.	TIMORE			OWITN	GS MILLS			11	Yes XXNo
i e	1	0e. Street end Number		1	10f.	Zip Code			g. Citizen of W	hef Country?	
a E							2111	7	U.S.	Α.	
Funeral	1	11110 HIDDEN TI	Armed Forces?	Ever in U,S.	13. Was De	ecedent of		Specify Yes or No- rto Rican, etc.)	14. Race	- American Inc	lian,
9 9		1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 V If Yes, Give Year or Dates:			s 2½ No		nto rican, etc.)	Specify:	k, White, etc.	TE
edical Exe		15. Decedent's I		166	e. Decedent's (Jsual Occu	petion	16	Sh. Kind of But	siness/Industry	
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To Be		ARNOLD		(GEHER		GITA		KEAF	ER	
-		9e. Informent's Neme/Reletionship	(Type, Print)	19	b. Mailing Add	ress (Stree	1	Rural Route Number, (City or Town !	State Zin Code)
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etho	2	CLARA GEHER / No. Method of Disposition	ATEE	20b. Plece	of Disposition	Neme of	TRAIL D		NGS MIL Oc. Location - (City or Town, S	21117 tate
		Buriel 2 Cremation 3			ery, cremetory		Z CHAIM	1/27/98	DALMIN	ODE M	
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any Injury once.	1	The Day of Pulled Service Serv	Louis	TA			S	ol Levinson Road Pik		_	
	+	23a. Putt. Enthy the disease, or cor shock, or hourt failure. List only	nplicetions thet caused	the death. Do							oximete
ician		shock, or hourt failure. List only	y one ceuse on each li	ne.						Inter	vei Between et end Death
dicai	1	mmediete Ceuse (Finel	11 +	,	-1						
niner	r	liseese or condition esulting in deeth)	e. Mreni				vas cul	ar dise	sse	10	ours
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y Physic	P	ert II. Other eignificent conditions	contributing to deeth b	ut not resulting	in the underlying	ng cause g	ven in Pert I.				ause of deeth
by Pt		Hypertentio	n					1 Yes	2 ☑ No	3 Probably	4 Unknow
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director, page 2	2	End stage 5. Wes case referred to medical exeminer? 1 Yes 2 No 7. Menner of Death	Hospital:	ent 2 ER/C		DOA OI	her: 4 \sum Nursing	-	ce 6 □Othe		
director, page 2	2	End stage 5. Wes case referred to medical exeminer? 1 Yes 2 No 7. Menner of Death 1 Nature 5 Pending investigation	Hospital: 1 Inpatie 28e. Dete of Inju (Month, Da	ent 2 ER/C	outpetienf 3/2	28c. Inju	her: 4 \sum Nursing	Home 5 ☐ Residen	ce 6 □Othe		
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director, page 2	2	End stage 5. Wes case referred to medical exeminer? 1 Yes 2 No 7. Menner of Death 1 Naturel 5 Pending investigating Suicide 6 Could not	Hospital: 1 Inpatie 28e. Dete of Inju (Month, Da	ont 2 ER/C ry y Year) 28b.	Outpetienf 32 Time of Injury M	28c. Inju Wo	her: 4 Nursing ry et rk?	Home 5 Residen 28d. Describe how 28f. Location (Stre	ce 6 □Othe	ed	e Number,
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death JANUARY 25, **Physician** 1998 B:25 AM WILLIAM JAMES HOLMES /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign **Funeral** 100M 20 F Months Deys Hours Min Yrs. Director with the Meryland 10e State 10b Counts 10c. City, Town or Locat 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours efter death with the Merylan ment of Health and Mental Hygiene.

Internal Rem 27 is marked other than "natural", or flems 23s or 28s-f show any or other traumatic svent, the Medical Examines must be notlined. 1 Yes 2 No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. 2 3 No 1 Never Married 2 Married 1 □ Yes 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT upe retired) 16b. Kind of Business/Industry 15. Decedent's Education College (1-4or 5+) Elementery/Secondary/9-12) 517 18. Mother's Name (First, Middle, Maiden Sumeme) Name (First, Middle, Last) Be /AR 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Ry rel Route Number, City or Town, State, Zip Code) MOTAER 20b. Plece of Disposition (Nem cemetery, cremetory or of 20e. Method of Disposition 20c. Location City or Town, Stete important: If it any injury or o once. 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) ter the disease, or complications thet caused the deeth. Do not enter the mode meet feiture. List only one cause on sech line. Approximete Interval Between Onset end Deeth of dying, such as cardiac or respiretory errest **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) PNEUMOCYSTIS PNEUMONIA Examiner Due to (or es e consequence of) Physician/Medicai Examiner ACQUIRED IMMUNE DEFICIENCY SYNDROME physician end s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Records, P.O. Box 68760. Due to (or es a consequence of) 98 esn for 23b. Did tobecco use contribute to the cause of deeth? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 3 Probably Unknown 1 Yes 2 No by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed pege 2 s has 1 Yes 2 No 1 Yes 2 No Ilficate | Vital 25. Wes case referred to medical exeminer? Be 26. Piece of Death (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 SInpatient 2 □ ER/Outpatient 3 □ DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Neturel 5 Pending 1 Yes 2 🗆 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours edical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 11-25-98 30263 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 7620 YORK ROAD, FRANCIS KHOO TOWSON, MD 21204 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature

wie Deviden

DHMH 16 Rev 6/95

Registrar

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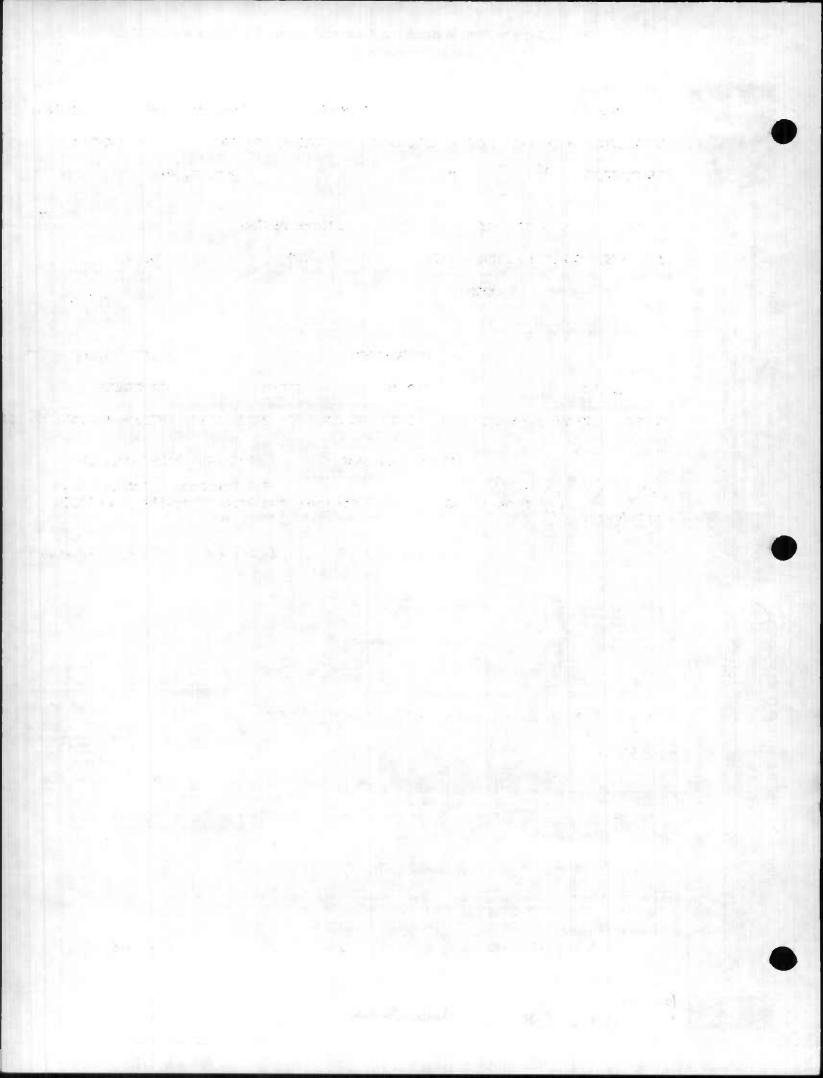
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State of Maryland / Department of Health and Mental Hygiene 8

				Certificat	e of	Death		R	eg. No.	C L	
	1. Decedent's Name (First, Middle,	ast)						2. Date of Deat Month	h Day	Year	3. Tima of Death
Physician /Medical	PHILIP			HA	RRI	S		JAN. 26			4:00PM
Examiner	4a Facility Name (If not institution, g	riva street and number	7)			4b. City, To	own, or Lo	ocation of Death	4c. County	of Death	
	HOLY CROSS HOS		VER SPRI			SILVE				NIGO	MERY
Funeral Director	5. Social Security Number 6 216-03-5115 Usual Residence of Decedent	Sex 7. A	ge (In yrs. last birth	Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day, DEC. 7	Year)	9. Birthp Cour	place (State or Foraign htry) MD
the Maryland 28a-f show notified at	10a. State 10b. County	ONTGOMERY	10c. City, Town	or Location	SIL	VER S	SPRIN	IG		1	10d. Inside City Limits 1 ☐ Yes 2 1 No
D P o it	10e. Street and Number		#1108	10f. Zip		2090			0g. Citizen of V		ntry?
urs after dea	11. Marital Status 1 Never Married 2 Married 3 Widowad 4 Divorced	12. Was Deceden Armed Forces 1	? (No	13. Was Dece If Yas, spe 1 ☐ Yes	37	dispanic Or an, Mexica Specify		ecify Yes or No- Rican, atc.)	14. Rac Blac Specify	ck, White,	can Indian, etc. HITE
ed within 72 hours ygiena. Ner than "natural", ft, the Medical Ex Completed by	15. Decedent's (Specify only highest of	Education grade completed)		Decedent's Usu Give kind of wo	rk done	during mos	st of work	ing	16b. Kind of Bu	usiness/In	dustry
within ena.	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT u	se retire	d)					
al Hygiens other the vent, the	12	-41\	PRO	PRIETOR		10 Math	ada Nam	o (First Middle)			QUOR STORE
Saby W	17. Father's Name (First, Middle, La ISAAC		HAR	RIS		CAT		e (First, Middle, I	Hanna	DIGIT	
C 8 9 6	19a. Informant's Name/Relationship SANDRA HELTZMAN		ER 19b.	Mailing Address 700 OLD	COL	end Numb	PIK	E #110	r, City or Town, B SILV	State, Zip ER SI	PRING, MD
of Fite	20a. Method of Disposition 1 Disposition 2 Cremation 3 4 Donation 5 Other (Spe		cemeter)	Disposition (Na , crematory or o YESHURU	ther pla	ce)	1	Date ./28/98	20c. Location - BALTIM		
permit. Pag Department Important: I any Injury o	21. Sanature of Funeral Service Lie	J. Leu	пΔ	22. Name at			Sol	Levins			
Physician /Medical Examiner	Immediate Cause (Final disease or condition or notification) Immediate Cause (Final disease or condition resulting in death)	ly one cause on each	od the death. Do not line. Or On Or Due to (or as a company)						est,		Approximate Interval Between Onset and Daath Ly Months
ricerificate to embulged nding physician and use as the fourst-transit n/M edical Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b	Due to (or es a co								
e death or the attend hed for us	Part II. Other significant conditions								obacco use co	ntribute t	o the cause of death?
that the ed by I detect	Congestive	heart f	milure	. Acc	ite	resi	pirat	TE 10 Y	es 2 No	3 Pro	bably 4 Unknown
been sign should be eted by	Congestive,	trotee		/				24a. Was a perfor		av	fere autopsy findings vailable prior to emplation of causa daath?
The law page 2								1 U Y	es 20 No	11	□Yes 2□No
centificate nector, pag Be Co	25. Was case referred to medical			_		26. Plac	e of Deat	h (Check only or	/		
	examiner?	Hospital:	tient 2 ER/Out	patient 3 De	Oth Oth	DOF:		ome 5 Reside		er (Speci	(v)
ding Physics After this stuneral di	27. Manner of Death Part Natural 5 Pending 2 Accident investigat	28a. Date of In (Month, D			28c. Inju			28d. Describe h			<i>,,,</i>
tal or Attending P at after death. In Director: After I led in by the funer: Certification:	3 Suicide 6 Could not	be 28e. Place of in	njury - At home, far etc. (Specify)	m, street, factor	y, office			28f. Location (S. City or Town		ber or Run	al Route Number,
Hospi Puns Funs dely fil		Physicien: To the bes aminer: On the basis and manner s	of axamination and								
To the to	29b. Signature and title of cartifier	ellen				se number	8	2	99d. Data signa		
et .	30. Name and address of person who GUL CHAISC					6-F) Iter	# 3/6	Rock	evu	er, MDzas
State Registrar	31. Date filed (Month, Day, Year) JAN 29	1998 32. Regis	trar's Signature	Pandale							7.13



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MA	RIAN	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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н	1		5-6	5-
U.	6	-1		

3. Time of Death

Physician
/Medical
Examiner

HIMTIEV

1. Decedent's Name (First, Middle, Last) Marian Huntley

2. Date of Deeth Month **JANUARY**

12,1998 9:20A.M. 4c. County of Death

4a Fecility Name (If not institution, give street end number)

Directo

Funeral

by

Completed

Be

2312 ETTING STREET

BALTIMORE

4b. City, Town, or Location of Death

Baltimore City

Funeral Director

"natural", or items 23a or 28a-f show adical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other treumetic event, the Healtest Examinations.

Physician

/Medical

Examiner

attending physician and for use as the burial-trensit

ed by the a

signed by t

been se

certificate has b

After this funeral

thin 24 hours efter the Funeral Direct mpletely filled in b

within 2 To the

deeth. Director: A

88

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

à

Completed

Be

7

Certification:

Medical

Baltlmore, Maryland 21215-0020

with the Marylend

r death

Usual Residence of Decedent 10a. State Maryland

unknown

5. Social Security Number

82 10c. City, Town or Location Days

If Under 1 Year | If Under 24 Hrs.

8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) April 7, 1915 unknown

10b. County

Baltimore City Baltimore

7. Age (In yrs. lest birthdey)

Yrs.

10d. Inside City Limits 1⊠ Yes 2 No

U.S.A.

unknown

10e. Street and Number

10f. Zip Code 21217 10g. Citizen of What Country?

2312 Etting Street

11. Marital Status unknown 1 ☐ Never Married 2 ☐ Married 12. Was Decedent Ever in U,S. Armed Forces? unknown 1 □ Yes 2 □ No If Yes, Give Year or Detes:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Raca - American Indian, Black, White, etc. Specify: Black

3 Widowed 4 Divorced

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+)

1⊠M 2□ F

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementery/Secondery (0-12) unknown

unknown

unknown

17. Fether's Name (First, Middle, Last)

unknown

unknown

18. Mother's Name (First, Middle, Maiden Surneme)

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

4 □ Donetion 5 ☑ Other (Specify) in state 21. Signatur of Roral Service Licensee Wade, Director

²² Name and Address of Fecility Board, 655 W. Baltimore Street Baltimore, Maryland 21201

23à Patt! Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a Atheroscleratic cardiovascular disease

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequenca of)

Due to (or as a consequence of):

Due to (or as e consequance of):

Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the cause of death?

1 Yas 2 No 3 Probably 4 Unknown

Approximate Intervat Between Onset and Death

24a. Was an autopsy performed? Inspection 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 M No 26. Plece of Death (Check only one)

1 Pyes 2 No

25. Was cese referred to medical examiner? 1X Yes 2□ No 27. Manner of Death

5 Pending Investigation

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 28c. Injury et Work? 1 Tyes 2 No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

(Check only one)

1. Natural

2 Accident

3 Suicide

4 Homicide

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

Hospitat:

O.C.M.E.

JANUARY 12, 1998

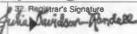
MP 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

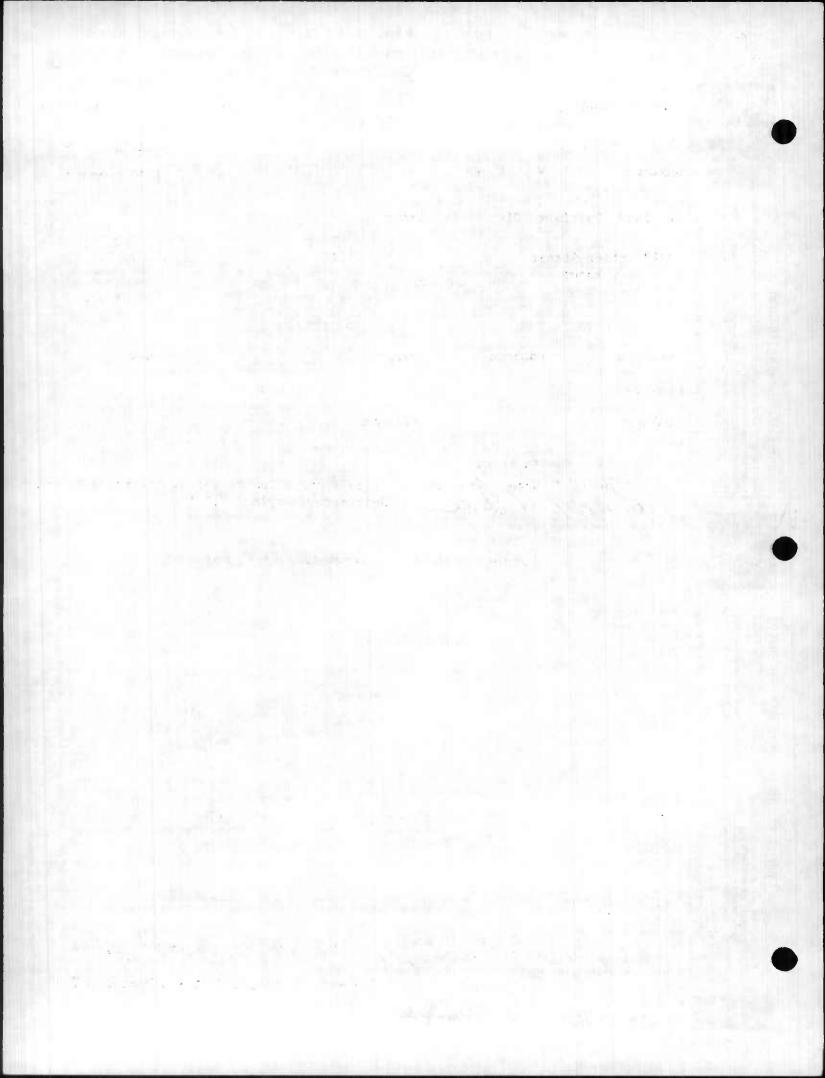
adentz phen

111 Penn Street, Baltimore, Maryland 21201

Registrar

31. Date filed (Month, Day, Year) JAN 29 1998



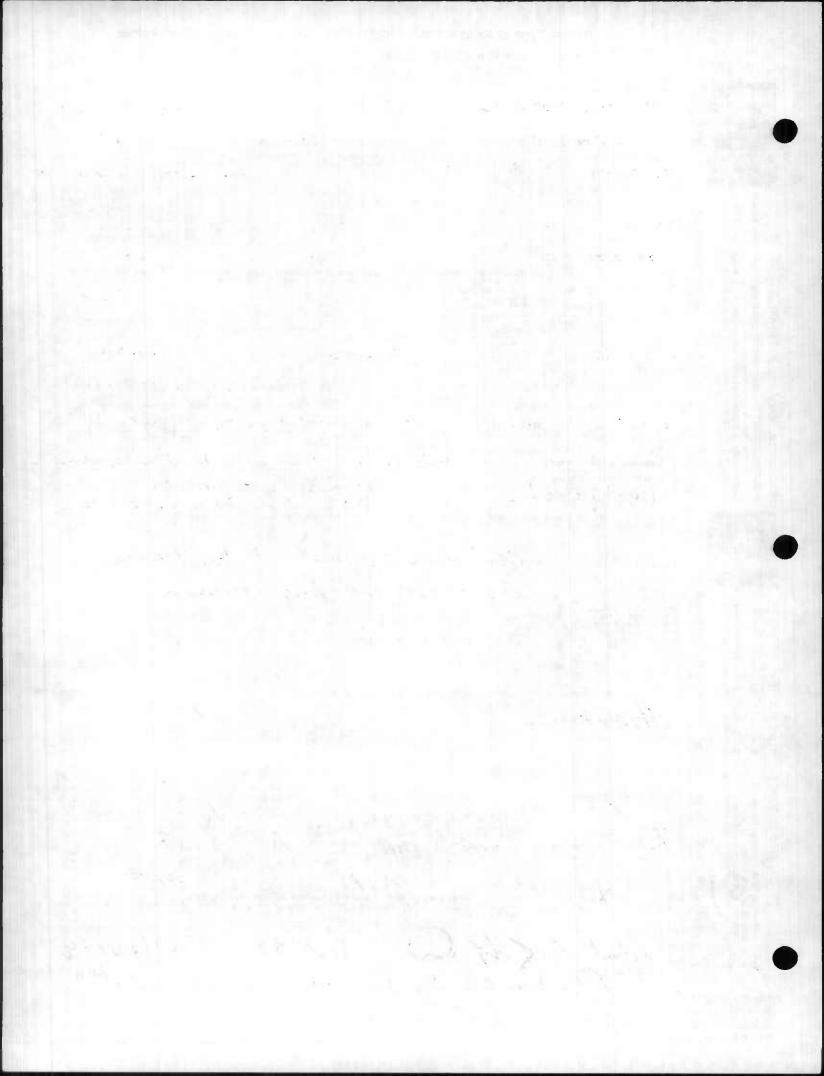


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				(Certifica	te of	Death		Re	g. No.	UZ	. 10:	3
		1. Decedent's Nama (First, Middle, Last)						2	Date of Death			3. Tima of	Death
Phys		Catherine Rack	rel Heil						Month	23, 19	98	3:00	PM
/Me Exan	dical niner	4a Facility Name (If not Institution, give s	treet end number)				4b. City, Tow			4c. County	of Death		
		124 Redbud Road	t				Edgew	ood		Har	ford		
Funer Directe		219-30-1/14	м 2 Б F 7. Age	(In yrs. lest birtl	months fs.	ar 1 Yaar Days	If Under 2	4 Hrs. 8 Min.	Date of Birth (Month, Dey, ug. 28,	Year) 1932	9. Birthple Count Penn	aca (Stete or ry) Sylvan	Foreign La
and **		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10	d. Inside Cit	v Limits
se-f sho	Director	Maryland Harford			Edgewo							1 🗆 Yes	2 No
1th with the 23s or 2 use the m	rai Dire	10e. Street and Number 124 Redbud Road					040				S.A.		
faryland 21215-0020 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or frems 23s or 28s-f show sumstice event, the Mexical Examiner must be notified as	by Funeral	11. Marital Status 1 Never Married 2 M Married 3 Widowed 4 Divorced	2. Was Decedant E Armed Forces? 1 ☐ Yes 2 💆 N If Yes, Give Year or Dates:		13. Was Dece If Yes, spo			in? (Speci Puarto Ri	y Yas or No- can, etc.)	Blac	e - Americe k, White, e : Whi	tc.	
Baltimore, Maryland 21215-0 semit. Pages 1 and 2 should be filed within 72 h bepartment of Health and Mental Hygiene. mportant: If Item 27 is marked other than "netun any injury or other traumatic event, the Mexical	Completed	15. Decedent's Educ (Specify only highest grade Elementery/Secondary (0-12)	ation completed) College (1-4or 5-		Decedent's Usi 'Give kind of w life. DO NOT	ork done use retire	pation during most of d)	of working	1	6b. Kind of Bu	siness/Ind		
d 2 Hygie ther		12th grade 17. Father's Nama (First, Middla, Last)			Homen	ukei	18. Mother	's Name (/	First, Middle, M				
Maryland 212. 4 2 should be filed within th and Mental Hygiene. 7 is marked other than traumatic event, fre.	Be C	Hiram Bows	D.M.						Margare				
aryla should nd Men marke	To	19a. Informant's Name/Relationship (Typ		19h	Mailing Addres	s (Street			Route Number,			Code)	
Mar nd 2 sho lth and 17 is m			isband)						od. MD			,	
or Health		20a. Method of Disposition	os surra j	20b. Place of	Disposition (Ne	eme of				Oc. Location		vn, State	
Pages lent of I		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Hill M			nx 1/	27/98 1	Raltimo	no I	Janula	ind
Baltimore Department of He mportant: If Item any injury or othe	ei .	21. Signatura of Funaral Sarvice Ligansa	θ ₄	Houg							ree, i	lucycu	.7101
Balt permit. Departrimports any inju	Succession	Folial froul			97	05 B	elair	Rd.	Homes, Baltim	ore. MI	21:	236	
. Box 68760, death certificate be executed warming physician and action use as the bunial-transit	al	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last	Non		Nonsequence of	-Sm					Piner	Onset and D	Deeth
O. E e dea	Sici	Part II. Other significent conditions conf	ributing to death bu	t not resulting In	the underlying	ceuse gi	ven in Part I.		23b. Dld tot	acco uae cor	tribute to	the cause o	of death?
ds, P.O. Box lires that the death cer signed by the attendin d be detached for use	by Phy	Hypertensio	u						15/10	s 2□No	3 🗌 Prob	ably 4□ l	Unknown
aw requisite should	Completed b								24e. Was an perform	eutopsy ed?	ava	re autopsy fi llable prior to npletion of ce leeth?	0
The law rate has by page 2 s	TO.								1 ☐ Yes	s 2/2/No	1□	Yes Z	No
Vital Inysician: The	Be (25. Was case referred to medicel exeminer?						of Deeth (Check only one)		- 1	
A 2 0 D	To To	1 Yes 2 No H	ospital: 1 Inpatier	nt 2 ER/Out	patient 3 C	OA		sing Home		nce 6 Oth	1-6-3)	
On O ding Ph th. After th funeral	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28e. Date of Injury (Month, Dey		me of jury	28c. fnju Wo			d. Describe hor	w injury occurr	ed		
SION seath. Tor After	catl	2 Accident investigation 3 Suicide 6 Could not be	NIS	+ 1	WITM	1	Yes 212N		(VI				
D TO	Certification:	4 Homicide determined	28e. Place of Inju- building, etc.	ry - At home, far . <i>(Specify)</i>	m, street, facto	ry, office		28	f. Location (Str. City or Town,	Stata)	er or Hurai	Houra Num	Der,
/ Kil	edical	29a. Certifier 11 Certifying Phys (Check only one) 2 Medical Examin	clan: To the best of er: On the basis of and manner stat	examination and									()
o de la comp	Me	29b. Signature and title of certifier	111	1	25	9c. Licen	se number	2	29	d. Date signe	d (Month, L	Jey, Year)	
5.55.9		> Robert 1-	8/1	(6-)		Da	2893	3		01/2	6/	19	
4		30. Name end eddress of person who co	mpleted cause of de	ath (Item 23e) (T	Type, Print)	100					19	Lite	Khielt
1		104 M/vmt	ree Kd	. Ste	-102	15	ie (Air	e hi O	21015	1	Jehl	A 1-01
	State	31. Date filed (Month, Dey, Year)	32 Begistra	r's Signature	2 2 00		,						

DHMH 16 Rev 6/95



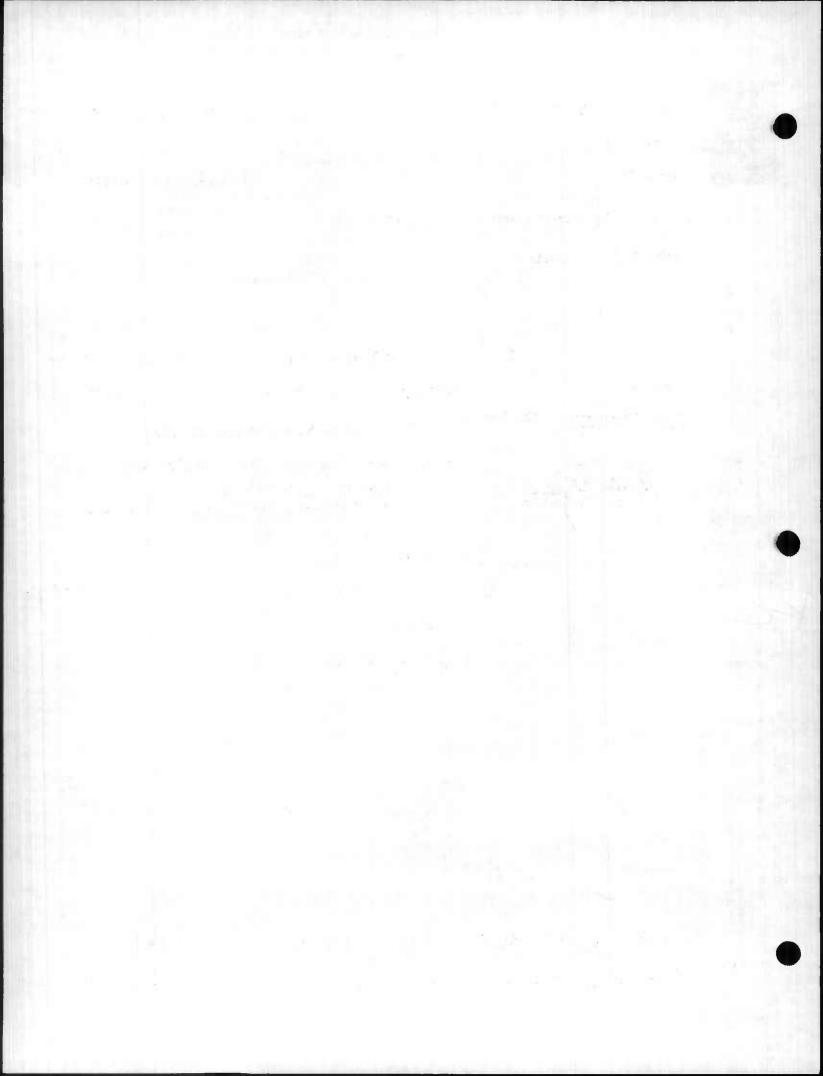
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 12:30 any SR. M. MARTINA HANZELY, M.H.S.H. 24, 1998 4c. County of Death January /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death Examiner THE VILLA Rodgers Forge Baltimore County 5. Sociel Security Number if Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Months Hours 1 □ M 2 💢 F Yrs. Director 584-42-8030 94 Oct.14, 1903 | Maryland Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits an "neturel", or items 23a or 28a-f show 1 ☐ Yes 2 No Maryland Director Baltimore County Rodgers Forge 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6806 Bellona Avenue 21212 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Reca - American Indian, Bleck, White, etc. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 20 5+ Religious Nun other Christian Ministry Baltimore, Maryland 17. Fether's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname, Pages 1 and 2 should be inent of Health and Mental int: If item 27 is marked o permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is merked any injury or other traumatic ev Martin Hanzely Julia 19e. Informent's Name/Reletionship (Type, Print)
Mission Helpers of the Sacred 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Heart: Motherhouse 20b. Place of Disposition (Name of Road, Towson, Maryland 21204, Stete cemetery, cremetory or other place) 20a. Method of Disposition 1 X Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) New Cathedral Cemetery

22. Name and Address of Facility 1/27/98Baltimore, Maryland 21. Signature of Funera Sansee Mitchell-Wiedefeld Home 6500 York Road, Baltimore Maryland 21212 enter the mode of dying, such as cardiac of respiratory errest. 23a. Pert1. Enter the disease, arcomplications that caused the deeth. Do not enter shock, or heart feilure. List only one ceuse on each line. Intervel Between Onset end Death **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner Mel Severed years Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es e consequence of) V Box 68760, 1800 Due to (or as e consequence of) thet initieted events resulting in deeth) Lest yroidism P.0. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings eveilable prior to completion of cause 24a. Wes en eutopsy Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes 2☑ No Certification: To 1 Inpatient 2 ER/Outpetlent 3 DOA # 27. Menner of Deeth Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After Attending 5 Pending investigation 1 Natural 1 🗌 Yes 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homiclde ò To the Hospital o within 24 hours at To the Funeral Di completely filled is Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as steted. 29a. Certifier Medicai 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signeture end title of cartifier 29d. Date signed (Month, Dey, Yeer) 29c. License number BS-5571585 26 8. 30 Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) 1200 S. HANOVER STREET BALTIMORE-MI)-21230 RATIBHA SHARMA 32. Registrer's Signeture 31. Date filed (Month, Day, Year) State ul Davidson

Registrar

29 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene of Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Daath 3 Time of Death JANYARY 26, 1998 MARY 0215 Hrs 4a. Facility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HUSPITAL RANDALISTOWN BALT, MORE | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, Year) | Positive (Month, Day, 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1□ M 2 F 86 217-12-9292 Yrs. Usual Residence of Decadani 10a Stata 10h County 10c. City. Town or Location 10d. Insida City Limits 1 Yas 2 No Maryland Baltimore County Lochearn 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 6811 Campfield Road 21207 U.S.A. 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 11. Mantal Status 1 Navar Married 2 Married 1 ☐ Yas 2 ☑ No Specify: White 3 Widowed 4 □ Divorced 15. Dacedant's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) (Spacify only highast grada complated) Elemantery/Secondary (0-12) College (1-4or 5+) 12th Grade Sales Retail Store 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Wayne Werntz Harry Anna Ault 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straet end Number or Rural Route Number, City or Town, Stata, Zip Coda) 5605 Whitby Road, Baltimore, Maryland 21206 Doris Rae Hummel/Daughter 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Other (Specify) Oak Lawn Cemetery 1/29/98 Baltimore, Maryland of Funaral Sarvice Licensea 22. Nama and Addrass of Facility
John C. Miller, Inc. 21. Signatur Manuta 23a. Part 1 tar the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shool of heart failure. List only one cause on each line. Smao 6415 Belair Road, Baltimore, Maryland 21206 Approximata Interval Batwaan Onsat and Death RESPIRATORY FAILURE Immadiata Causa (Final disaasa or condition rasulting in deeth) Dua to (or as a consequence of):

PNEUMONIA Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaase or Injury that initiated avants resulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consaguanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco uee contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings availabla prior to complation of causa of deeth? 24a. Was en eutopsy parformed? 1 Yas 2 KNo 1 ☐ Yes 2 ☐ NO 25. Was case refarred to madicel 26. Placa of Daath (Check only ona) Hospital: 1 → Popatiant 2 □ ER/Outpatient 3 □ DOA Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work?

Physician /Medicai **Examiner**

Physician

/Medicai

Examiner

Funerai

Director

28a-1 show must be notified at

ö items 23a

0

"natural"

n and Mental Hygiene.

Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 is marked oth lury or other treumatic even

permit. Page Department of Important: If i eny injury or

treumatic event, the Medical Examiner

Director

by

Completed

with the Maryland

filed within 72 hours after death

21215-0020

Baltimore, Maryland

Box 68760 Records, certificate Division of Vital this

Examiner Physician/Medical þ Completed Be 2 Certification:

d or Attending P. after death. I Director: After I To the Hospital of within 24 hours a To the Funeral D completely filled

1⊈ Cartifying Phyalcien: To tha best of my knowledge, death occurred et tha time, data and place, and dua to the ceuse(s) end mennar as statad. Medical 29a. Cartifiar (Check only one) 29b. Signatura and title of certifiar

1 Natural

2 Accidant

3 Suicida

4 Homlcide

State Registrar

5 Panding

invastigation

6 Could not be datarmined

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

2 Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, date and place, end dua to the cause(s) and mannar statad. 29d. Date signed (Month, Day, Year) 29c. Licensa number 037333 JANYARY 26, 1998

28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Steta)

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print)

C. RAVI MO, NHC, BALTO MD 21133 C. RAVI MO, NHC.

1 ☐ Yas 2 ☐ No

32. Registrar's Signature 31. Data filad (Month, Day, Yaar) JAN 29 1998

WRC 98-0413-510 CHARLES R.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

HA	RLOW			State	or Mary	nand / 1		tificate			thu iv	ientai m	Reg. No	971	Û	2192
	Physician /Medical	1. Decedent's Nem Charle		Lasi) rt Harlov	V							2. Dete of D Month JANUAF	Dey		Yeer 98	3. Time of Deeth 7:50 PM.
	Examiner	4e Fecility Neme ((If not institution, SHIREY A		umber)				4		wn, or Lo	ocation of Dee ORE	th 4c.	County N/A		
	Funeral Director	5. Sociel Security P 218-70-70	011	6. Sex 1Ã M 2□ F	7. Age (In	yrs. last bi	Yrs.	If Under 1 Months I	Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D Feb.	irth Day, Year) 9, 19	58		plece (Stete or Foreign intry) Yland
	Maryland Let ahow Lind at	Usuel Residence of 10a. Stete Maryland	10b. County N/A			c. City, Tow Baltin										10d. Inside City Limits 11 Yes 2 □ No
	ifier death with the Ma r fems 23a or 28a-fa ciner must be notified Funeral Director	10e. Street end Nu 2705 Shi:		nue		50		10f. Zip C						izen of W	Vhet Cou	intry?
020	Mr. o	11. Merital Status 1 Never Man 3 Widowed	ried 2□ Marrie	12. Wes Der Armed F 1 Tyes If Yes, G Yeer or	orces? 20 No live	r in U,S.		/as Deceder Yes, specify □ Yes 2K		ispenic Ori en, Mexican Specify:	gin? (Sp , Puerto	ecify Yes or N Rican, etc.)	lo-		k, White	ican Indien, , etc.
altimore, Maryland 21215-0020	ed within 72 ho ygiene. Nor than "naturi it, the Medical Completed	(Spe Elementery/Sec 12th Gra	ondery (0-12)	grade completed) (1-4or 5+)		(Give k	ent's Usuel (ind of work O NOT use Drive	done d retired	ation during most	of work	ing		ind of Bu		ndustry
/land	build be filled within Mental Hygiene. arked other than " atic event, the Ma To Be Comple	17. Father's Neme James			arlow					18. Mothe Virg		e (First, Middl M.	le, Meiden	-	e) Brow.	n
Man	1 and 2 should Health and Mer em 27 is merke ther traumatic	19a. informant's N James E.										el Route Num altimo:				
imore,	10 = - 20			3 □Removel from ecify)				ition (Neme etory or oth Washi								own, Stete
Balt	pemit. Pag Department Important: I any Injury o	21. Signature of F	. 4	OOL-	nan		Jo.	Name end nn C. 15 Bel	Mi	ller,	Inc	altimo	re, N	ary.	Land	21206
	Physician /Medical	23a. Part Futer should her her her her her her her her her her	the disease, or cart failure. List of	complications that inly one cause on									errest,		1	Approximete Intervel Between Onset end Death
	Examiner	resulting in death)		θ		to (or es e			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(60						
90,	e becuted una and unal-transi	Sequentially list or if eny, leeding to in cause. Enter Und Ceuse (Disease or	onditions, mmediate erlying	b	Due	to (or es e	consequ	ence of):							1	1913
P.O. Box 68760	at the death certificate be associated by the attending physician and etached for use as the buffal-transf. Physician/Medical Examiner.	that initiated event resulting in death)	S	d	Due	to (or es e	consequ	enca of):								
, P.O. B	o that the death ned by the atta e detached for y Physicia	Pert II. Other signi		ns contributing to	death but no	ot resulting	in the un	derlying cau	se giv	en in Pert I			d tobecco	120	ntribute 3 Pr	to the cause of death?

Be Completed certificate has 10 Certification:

Division of Vital Record sepital or Attending Physician: hours after death. meral Director: After this carifica To the P

Medical

State Registrar

30. Name and address of period who completed cause of death (Item 23e) (Type, Print) Dennis , up 31. Date filed (Month, Day, Year)

JAN 29 1998

5 Pending investigation

6 Could not be determined

25. Wes case referred to medical examiner?

1

↑

Yes 2

No

29b. Signeture and title of certifier

27. Menner of Deeth

1 Naturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

32. Registrer's Signeture who Davidson-Randall

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient

28a. Dete of Injury (Month, Day Year)

3□ DOA

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28b. Time of Injury

28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as stated.

**Common Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner stated.

**Common Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Year) 29c, License number

26. Plece of Deeth (Check only one)

O.C.M.E. JANUARY 27, 1998

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

24a. Was en eutopsy performed?

1 TYes 2 □ No

28d. Describe how injury occurred

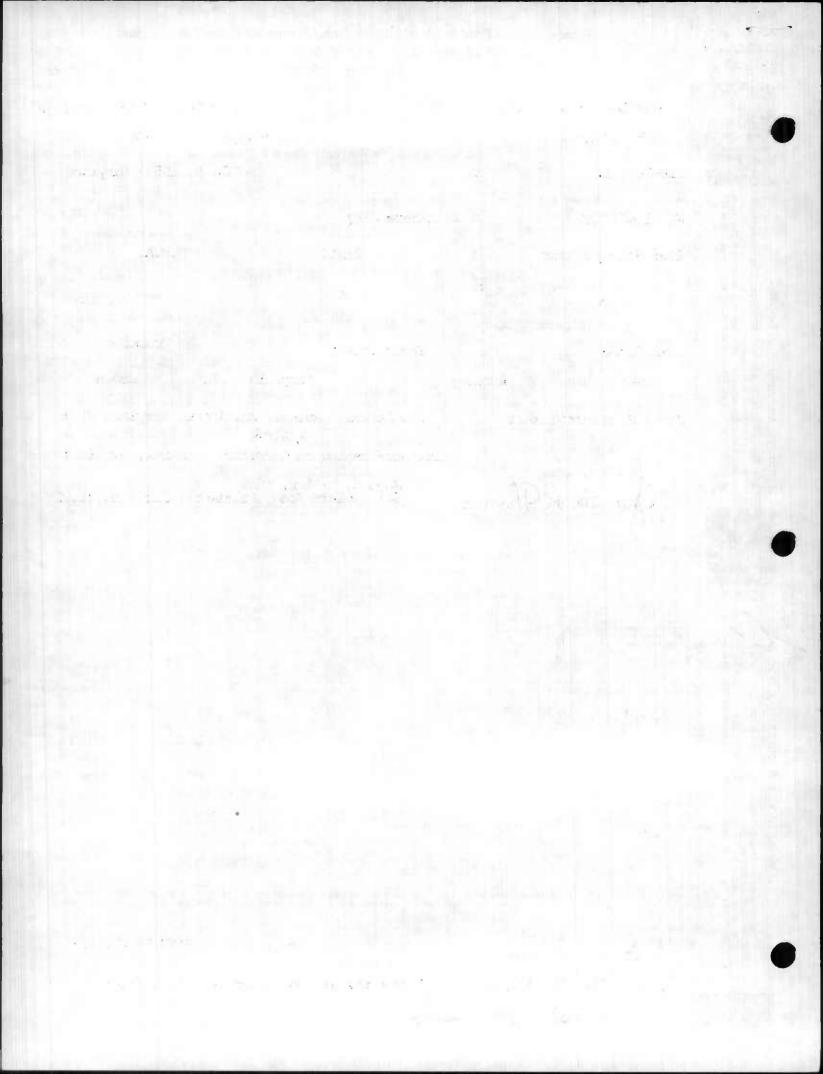
28f. Location (Street end Number or Rural Route Number, City or Town, State)

24b. Were eutopsy findings evellable prior to completion of cause of death?

1 Hes 2□ No

111 Penn Street, Baltimore, Maryland 21201

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Item: 18 Per FH Film G-755 1-29-98RC Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** OHNISON 6:45AM /Medical 4c. County of Deeth 4b, City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) **Examiner** Saltimore 5 Prtal 7. Age (In yrs. last birthday) 33 Yrs. NA 5. Sociel Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Deys Hours Min 1 M 2 F 220-82-1555 Director Usual Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rthan "natural", or Items 23e or 28a-f showing Medical Examiner must be notified at 1d 1 Yes 2 No NA Director 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? filed within 72 hours efter deeth with 21230 2418 USA LOUR Maisel Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ NO 14. Race - American Indian Bleck, White, etc. 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Yes Give 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decadent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than eny injury or other freumstic event, the Mental place. 1244 UNEMPlayed NA NA 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be IURONE JOHNSON 2 Johnson atricia 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Hilton St Pateicia Johnson-Mother N. Dalto 1709 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, crematory or other plece) 20c. Location · City or Town, Stete 1 ☐ Buriel 2 ☐ Cremettion 3 ☐ Removel from State 4 Donetion 5 Other (Specify) 1.3198 MEMORIAI Yark 22. Name end Address of Fecility

22. Name end Address of Fecility

23a. Pert Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart injure. List only one cause on each line. Ho. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): ding The law requires that the death Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of deeth? signed by 1 ☐ Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were eutopsy findings eveileble prior to 24a. Wes en eutopsy performed? completion of cause of deeth? TOG After this certificate. cem 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 5 ☐ Residenca 6 ☐ Other (Specify) 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Certification: Attending 5 Pending investigation Injury 1 Naturel death. 1 Tes 2 No 2 Accident To the Hospital or Attent within 24 hours after deal To the Funeral Director: 96 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete and piece, and due to the ceuse(s) end menner es steted.

2 Madical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end pieca, end due to the cause(s) and menner steted. 29a. Certifier Medical

State Registrar 29b. Signatu

30, Neme

and the of certifier

and addres

31. Date filed Month Day Year



940 W.

of person who completed cause of deeth (Item 23a) (Type, Print)

29c, License number

BAUT ST.

29d, Date signed (Month, Dey, Year)

Piease Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day HERBERT DAVID JONES, JR. 98 16:55 4a Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Yrs. 63 216-30-9509 1/14/35 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 1 XYes 2 No MD N/A BALTIMORE 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 4515 NORTHWOOD DRIVE 21239 U.S. 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, 2 No if Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Ricen, etc.) Black, White, etc. 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICAL TECHNICIAN DEPT. OF TRANS. 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HERBERT DAVID JONES, SR. DORA WEAVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY L. JONES (WIFE) 4515 NORTHWOOD DRIVE-BALTO, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 1/27/98 RANDALLSTOWN, MD 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility ELIZABETH L. PHILLIPS ectsp 1721-27 N. MONROE STREET-BALTO. MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): DISEASE BOWEL VASCULAR DISEASE ATHEROSCLEROTIC Due to (or as a consequence of 23b. Dfd tobacco use contribute to the cause of deeth? 1 Yee 2 No 3 Probably 4 Unknown STAGE RENAL DIJEASE 24b. Were eutopsy findings available prior to 24a. Was an autopsy completion of cause of deeth?

Physician /Medical Examiner

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certificate

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After

A Hospital or Attending 24 hours after death. Puneral Director: Ah

24 hours a

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Completed

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Certification:

Medical

Division of Vital Records, P.

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

r than "natural", or items 23s or 28s-1 sho

al Hygiene.

s 1 and 2 should be filed v of Health and Mental Hygie Nem 27 is marked other th other traumatic event, in

Pages 1 and 2 nant of Health at nt: if Item 27 is 1

permit. Page Department of Important: If any Injury or once.

Baltimore,

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION

6 Could not be determined

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

1 ☐ Yes 2 XNo

25. Was case referred to medicel examiner?
1 ☐ Yes 2 ☑ No 27. Manner of Death 5 Pending Investigation 1 Natural 2 Accident

28a. Date of Injury (Month, Day Year)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

JAN 291998

29c. Licansa number

29d. Date signed (Month. Dav. Year)

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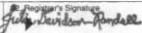
D35706

01/28/98

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

MD 5601 Loch Raven Blvd., #410, Baltimore, MD Elias C. Ghandour, 31. Date filed (Month, Day, Year)

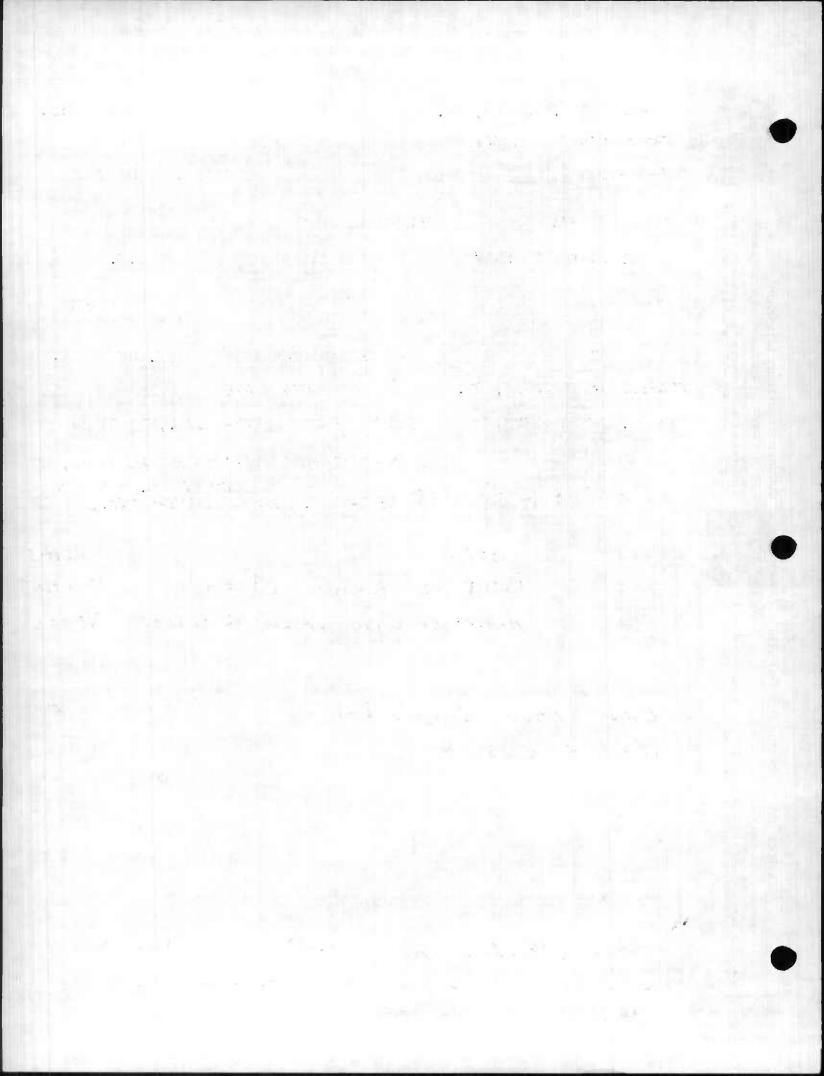
Registrar



1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

21239

1 ☐ Yes 2 X No



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month HERMAN JOHNSON /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner MENERA DORCHESKE CAMBRIDGE NOSPITAL Dorchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8-Dete of Birth (Month, Dey, March 15 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 2□F Months Deys Hours Yrs. 217.30-9950 Director 86 Florida Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits reast be notified at MD DORCHESTER CAmberdge Director 1 Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? STREET 21613 614 4.5. Funeral 2. Wes Decedent Ever in U.S. Arrhed Forces? unknown 1 | Yes 2 | No If Yes, Give Year or Detes: Пете Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, *Black, White, etc. 11. Marital Status traumatic event, the Medical Examiner 1/2 Never Married 2 ☐ Married 21215-0020 6 1 Yes 2 No Specify: Specify: BIACK Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) Truck Driver Unknown unknown unknown permit. Pegas 1 and 2 should be filed Department of Health and Mantal Hygi Important: If item 27 is marked other any Injury or other traumatic event. ■ Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Unknown Unknown 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Leola Burgess/niece unknown 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetlon 5 NOther (Specify) in state 21. Signature of Funeral Service Licenses Ronal S. Wade 22. Name end Address of Fecility State Anatomy Board, 655 W. Baltimore Street Director Baltimore, Maryland 21201
23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Sepsis Examiner Due to (or es e consequence of) Examiner The lew requires that the death cartificate be executed Tras Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In deeth) Lest pue Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of) ata hes been signed by the e page 2 should be datached Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown g 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? this certificata 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 21 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of Injury 28d. Describe how Injury occurred 28c. Injury et Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital o within 24 hours af To the Funeral D complately filled i 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier

29c, License number

29d. Date signed (Month, Day, Year)

State Registrar

29b. Signeture and title of contain

31. Date filed (Month, Day, Year)

32. Registrer's Signature Julia Davilson

MD

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

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DHMH 16 Rev 6/95

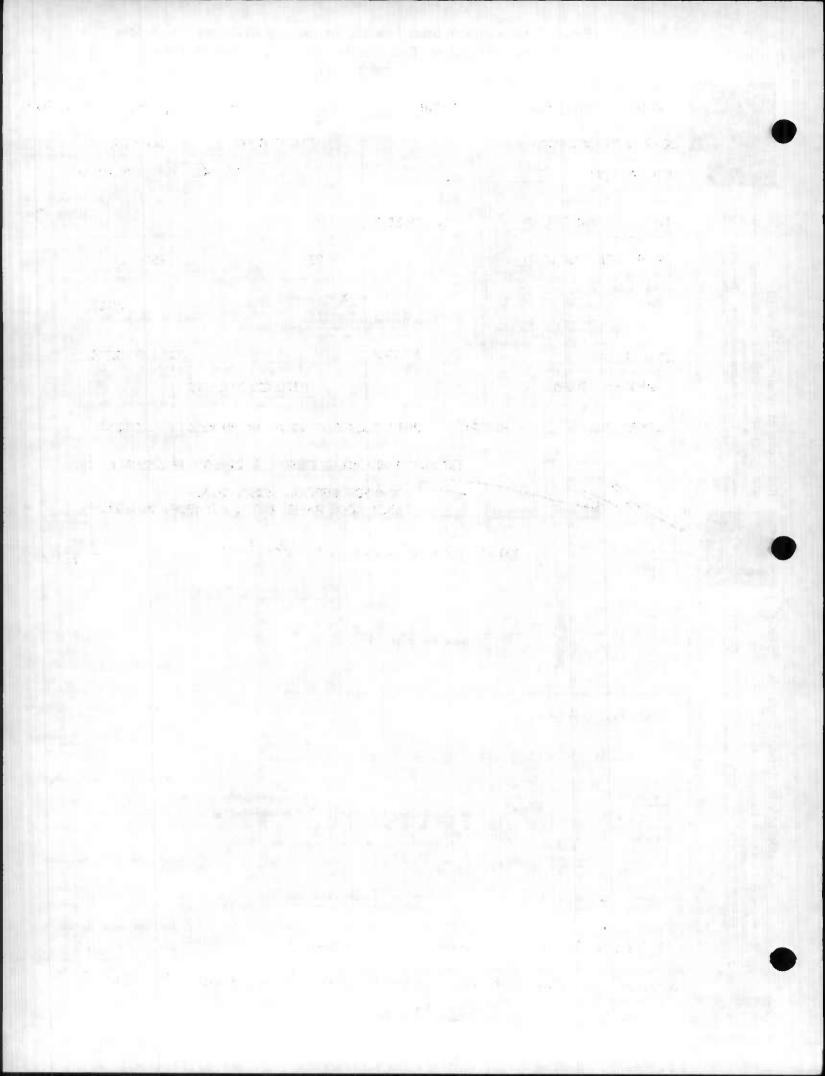
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State of Maryland / Department of Health and Mental Hygiene S

Certificate of Death 2. Data of Deeth 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) Month Dev **Physician** JOHN JUSTH 4:00 A.M. WILLIAM JAN. 25, 1998 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8614 ROCK OAK ROAD RIDGELEIGH BALTIMORE If Undar 1 Year It Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Sacurity Number 6 Sax 7. Age (In yrs. lest birthday) **Funeral** Months Days 1 M 2□F Yrs. 2/4/41 Director MARYLAND 213-38-8871 Usual Rasidance of Decedan the Marylend 10d Inside City Limits 10a State 10b. County 10c. City. Town or Location r 28a-f show worle 1 ☐ Yas 2 X No Director MD BALTIMORE RIDGELEIGH 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with "naturel", or items 23e or permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23e and hijury or other traumatic event, the Medical Examiner man and page. 8614 ROCK OAK ROAD 21234 Funeral USA 12. Was Decedent Ever in U,S. Armad Forcas? TV☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 11. Marital Status Separated 14. Race - American Indien, Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Bleck, White, atc. 1 Navar Marriad 2 Married Saltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada complated) (Giva kind of work done during most of working lifa. DO NOT usa ratired) College (1-4or 5+) Elementery/Secondary (0-12) MECHANIC 12th GRADE BOB DAVIDSON 18. Mother's Nama (First, Middla, Maidan Sumema) 17. Fethar's Nama (First, Middla, Last) Be HARFORD JUSTH MILDRED ZANDERS 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Typa, Print) 8614 ROCK OAK ROAD BALTIMORE, MD 21234

Data 20c. Location - City or Town, Stata MILDRED JUSTH MOTHER 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) MORELAND MEMORIAL PARK 1/27/98 HILLENDALE, MD 21. Signature of Funaral Sarvice Licensee 22. Nama end Address of Facility JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD TOWSON, MD shock, or haart failura. List only one cause on each line. 21.286 Approximete Intarval Between Onset and Daath Physician metastate Concer of /Medical Immadiata Causa (Final disaasa or condition resulting in deeth) years Examiner Dua to (or as a consequance of): Examiner Sequantially list conditions, if eny, leading to immediata causa. Enter Underlying Ceusa (Disease or Injury that initiated avants resulting in daath) Last Dua to (or as a consequanca ot): Box 68760 8 Physician/Medical Due to (or es e consequence ot): the death certificate 98 use signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2No No 3 Probably 4 Unknown Stenosis Aortic Division of Vital Records, þ The law requires 24b. Ware autopsy tindings avellabla prior to complation of cause ot death? 24a. Was an autopsy performad? Completed ils certificate hes t i director, page 2 s 1 ☐ Yas 2 No 1 ☐ Yes 2 No Attending Physician: 25. Was cesa retarred to madical axeminar? Be 26. Piece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Data ot Injury (Month, Day Yaar) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding 1 Netural 1 ☐ Yas 2 ☐ No death. investigation 2 Accidant ector: 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Spacify) n 24 hou. The Funeral Directifiled in by or A efter 4 D Homicide 1 To the best of my knowledga, daath occurred at the time, date end plece, and dua to tha cause(s) and mannar es stated.
2 Medicat Examinar: On tha basis of axamination and/or invastigetion, in my opinion, deeth occurred at the time, date and place, and dua to tha cause(s) and mannar stated. edical 29a. Cartifiar compietely (Check only To the To the To the I 29c. Licansa number 29d. Data signed (Month, Dey, Year) 29b. Signatura and titla of certifian 01-26-98 D00467 Street H 13 rage 30. Nama and eddress of person who complated ceuse of daath (Itam 23a) (Type, Print) 4+ 2360 W. JOPPARD LUTHERVILLE MD 21093 BRAGER MD Registrar's Signatura 31. Data tilad (Month, Day, Yaar) who Davidson Randall 29 1998 JAN Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Daath Month Tubes Florence 0239 A 1998 January 23 4a. Facility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Undar 1 Year If Undar 24 Hrs. Months Days Hours Min. 8. Data of Birth (Month, Day, Yaar) JAN. 21, 1910 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthpleca (Stata or Foraign Country) Days 1□ M 21 F 153 22 6748 88 Yrs. NEW JERSEY Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY DERWOOD 1 Yas 2 No 10a, Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 17905 CLIFFBOURNE LANE 20855 UNITED STATES 12. Was Dacedant Evar in U,S. Armed Forces? 13. Was Decedant of Hispenic Origin? (Spacify Yes or No If Yas, specify Cuban, Mexicen, Puarto Ricen, atc.) Race - Amaricen Indian, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 No Specify 3 ₩idowed 4 Divorced WHITE 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) FRED HUREY UNKNOWN 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straet and Number or Rural Route Number, City or Town, Stata, Zip Coda) 17905 CLIFFBOURNE LANE, DERWOOD, MD. 20855 e of Disposition (Nama of Data 20c. Location - City or Town, Stata RICHARD F. JUBERT, SON 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramovei from Stata HOLLYWOOD MEMORIAL PARK 1/29/98 4 ☐ Donation 5 ☐ Othar (Specify) UNION NEW JERSEY 21. Signatura of Funarel Sanfice Licensas MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fail ire. List only one ceuse on each line. Approximata Intarval Between Immediata Causa (Finel disaasa or condition rasulting In death) heumoma Due to (or es e consequança of): Suther 22 do disease Due to (or as a consequence of) (Droma-Dua to (or as e consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 CUnknown 24b. Wara autopsy findings availabla prior to completion of cause of daath? 24a. Was en eutopsy parformad? 1 Yas 2 No 1 ☐ Yas 2 No 26. Plece of Death (Check only one)

Physician /Medical Examiner

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To the Hospital or within 24 hours effe To the Funeral Dir completely filled in

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

pemit. Pages 1 end 2 should be filed within 72 hours efter deeth .
Department of Heelth end Mental Hygiene.
Important: If fem 27 is marked other than "natural", or have non yilyury or other trainers.

Baltimore, Maryland 21215-0020

with the Maryland

Sequantially list conditions, if eny, laading to immadiate cause. Enter Undarfying Causa (Diseasa or Injury that Initiated avants rasulting in daath) Last

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Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 28c. Injury at Work? 28d. Dascribe how injury occurred

TIKE

5 Pending invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida 28e. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 4 Homicide

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifie

to Cartifying Phyalclen: To the best of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) end menner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signad (Month, Day, Yaar)

29b. Signetura and titla of certifiar

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31. Data filed (Month, Day, Yaar)

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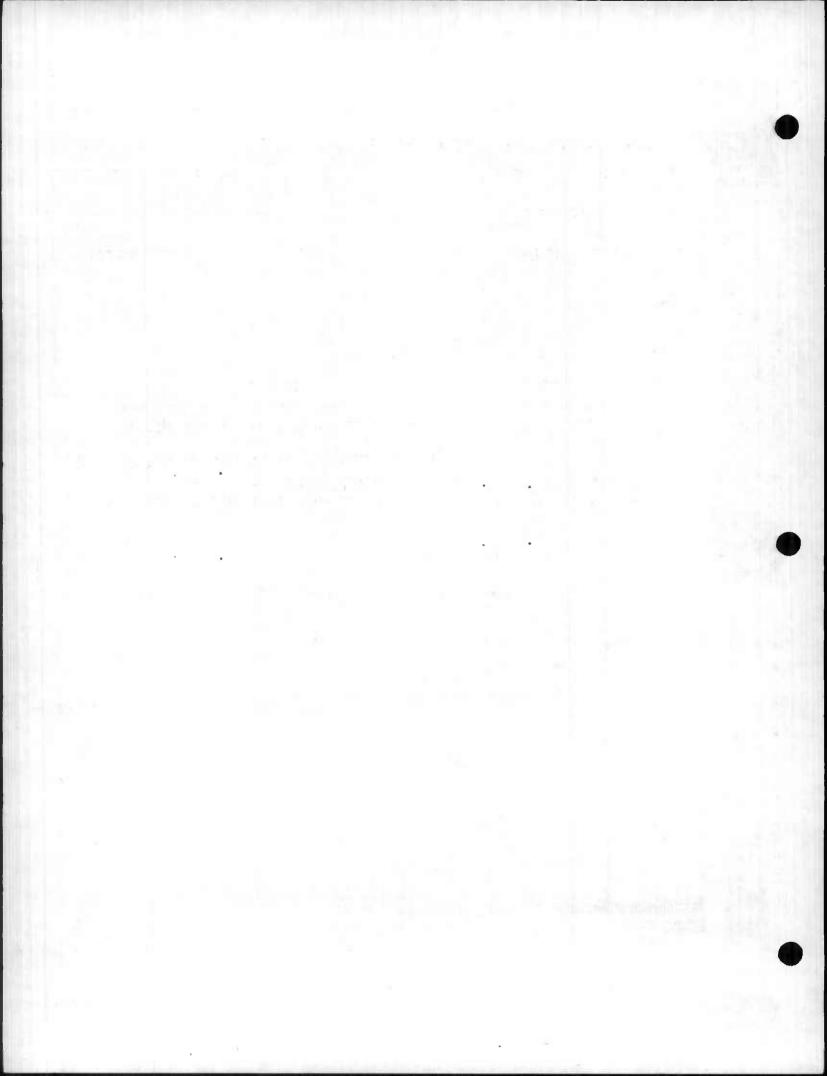
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30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

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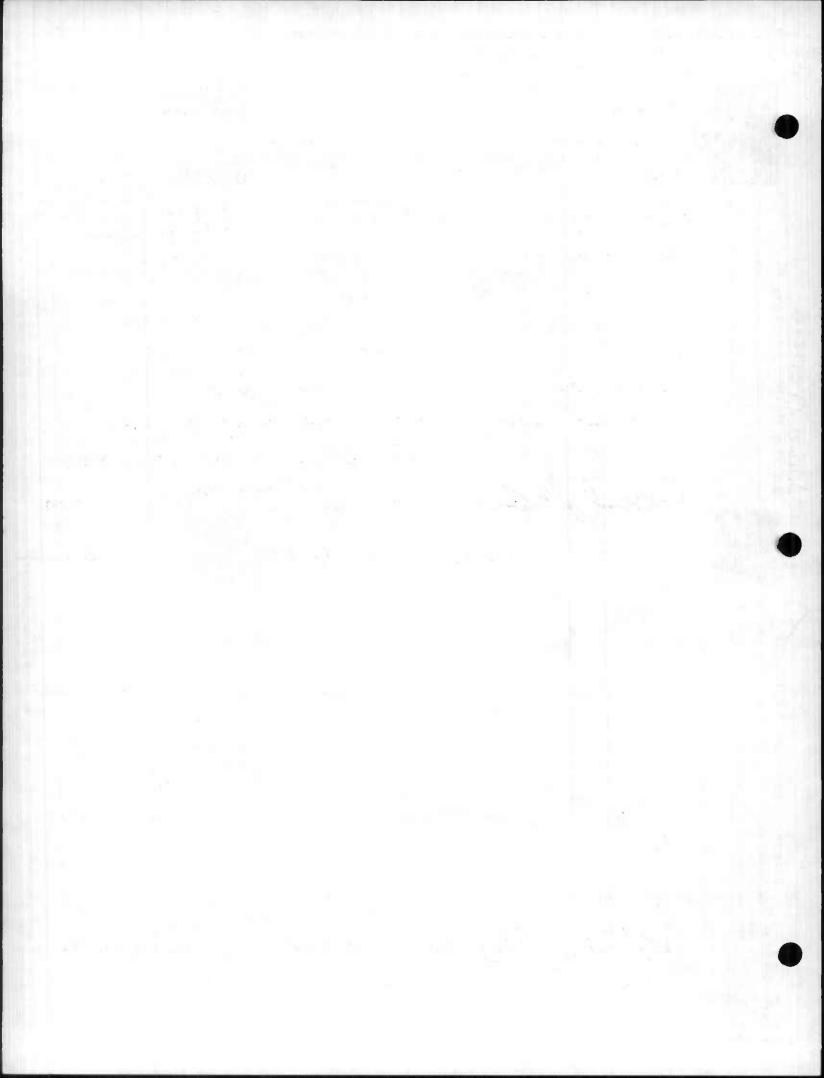
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State Registrar 32. Registrar's Signatura Lina Daydson



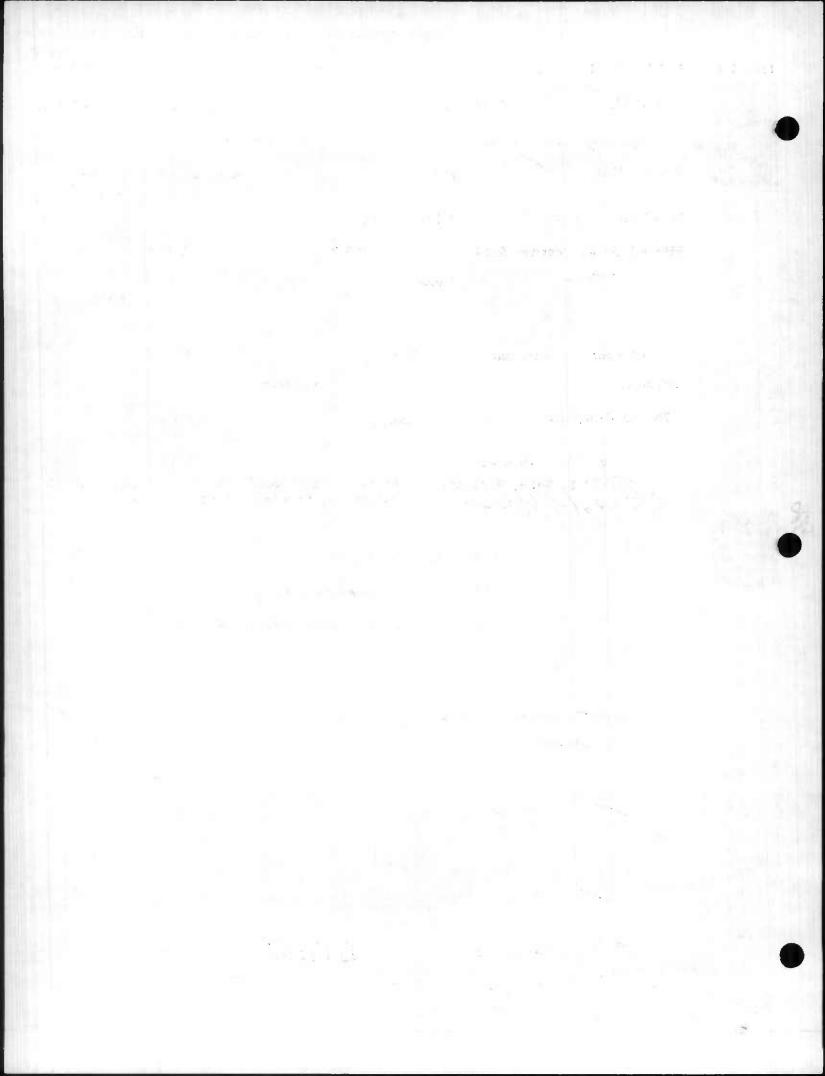
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hysician /Medical		Janina Kasprzak							VO.OU	1 6	3 1998 C	7:00
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o di la	9 .	7834 St. Bridget	Lane			212	22			Pol	and	
tr. or llerne 23e or 28e-1s Examiner must be notified by Funeral Director		11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 27 If Yes, Give	? X No	If Y	es Decedent of Yes, specify C	of Hispenic Originates, Mexican No Specify:	gin? (Spe , Puerto I	cify Yes or N Ricen, etc.)	0- 1-	4. Race - Ame Bleck, White Specify: Wh	te, etc.
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1	5	6th	Collage (1-40)	34)	House	wife				Dome	stic	
matic event, 1		17. Father's Name (First, Middle, Last)				18. Mothe	r's Neme	(First, Middle	, Maiden S	Sumame)	
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0.5		19e. Informent's Name/Ralationship (eet and Numbe					
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5 6	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Othar (Specit		B C6	lece of Disposit emetery, crema Ly Rosai	tory or other	olace)	1	Dete /24/98		imore,	Town, Stete Marylan
any injury once.		21. Signature of Funeral Service Liber 23a. Pert1. Enter the disease or com shock, or heart failure. List only	3 Show	ad the death	Day 401	vid J. I s. ch	Weber : nester :	Fune:	Balti	more,	Maryl	and 2123
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is cernicate nes been signed by the attending physical director, page 2 should be deteched for use as the but To Be Completed by Physiciary/Medical		Sequantially list conditions, if eny, leeding to immediate cause. Enter Undarfying Ceusa (Disaase or Injury that initieted avants resulting in daath) Lest	b c d contributing to death	Due to (or Due to (or	r es e conseque	ence of): ence of): erlying ceusa	givan In Pert I.	of Deeth	1 🗆	Yes 2	(No 3 □ P	ware autopsy fin eveileble prior to completion of cet of daeth?
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State of Maryland / Department of Health and Mental Hygiene Item: 10e Per FH Film G-755 1-29-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** CARL Kenter 1)) JAM 2/ /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard cal ungit 1 towns CT GFH 14040 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F 300-05-9738 Yrs. Director (51) unknown Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Tes 2√2 No Director Maryland Howard Ellicott City 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ō 21042 3339 N. Chatham Road 21042 U.S.A. 230 Funeral 12. Wes Decedent Ever in U.S.
Armed Forces? unknown
1 □ Yes 2 □ No
If Yes, Give
Yeer or Dates: Herns 11. Maritel Status unknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ŏ 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 7 Hygiene. marked other than College (1-4or 5+) Elementery/Secondary (0-12) unknown unknown unknown unknown parmit. Pagas 1 and 2 should be file Department of Heelth and Mental Hy Important: If them 27 is marked othe any injury or other traumatic averaging the street of the street the street of the street the street of the street the street of the street the street of the street the street of the street the street of the street 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be unknown unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Hahn/sister unknown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ▼Other (Specify) in State 21. Signeture of Funeral Service Licensee Royald S Wade State Anatomy Board, 655 W. Baltimore Street Director Ruce Baltimore, Maryland 21201 23a. Parl 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final CARDIAC disease or condition resulting in deeth) MPRES: Examiner Due to (or es a consequence of): Examiner ARRHY THMIA PROMANCE--transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Lest pue Due to (or es e consequence of): physician the burial Box 68760. ATHERESCEROTTE CARRIO VASCULAR requiras that the death certificate be Physician/Medicai Due to (or es a consequence of): attanding for use as P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 | Yes 2 | No 3 | Probably 4 | Whiknown ROUNION 0-12 Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed AMPJENDON STUMP peen : paga 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No this cartificata of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifica 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide n 24 hours af ne Funerel DI oletaly filled In 1 🖵 🗲 certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as steted. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JM 21, 1952 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) B. G. VORTOLAMI 827 LIMDEN DE 2 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Julia Dividson-Randalle Registrar

DHMH 16 Rev 6/95



		State	of Maryland / Depa			Death			ene g. No.	0	2200
1. Decedent's Nam	e (First, Middl	le, Last)						2. Date of Deeth		Yeer	3. Time of Death
	Ka	rl Willi	am Klug					JANUARY	24', 19	98	06:25 AM
		n, give street and nu APSCO AVE	,			4b. City, To BALTI		ocation of Deeth	4c. Count	y of Death	
5. Sociel Security N 216-82-79		6. Sex 10 M 2□ F	7. Age (In yrs. last birthday) 35 Yrs.	If Under 1 Months	Year		24 Hrs. Min.	8. Date of Birth (Month, Day, July 18,	1962	9. Birth Cou Mar	place (State or Foreign intry) y l and
Usual Residenca o	f Decedent										
10a. State Mary land	10b. County	imore	10c. City, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2☐ No

10f. Zip Code

21227

10e. Street and Number

Director

Funeral

by

Completed

"natural", or items 23a or

Physician /Medical

Examiner

signed by i

page 2

certificate

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a for Attending Patter death.

Director: After

8 To the 2 within 2 To the I

Hospital

Unersi

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10g. Citizen of What Country?

1720 Hall Avenue

11 Marital Status

12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes AZNO If Yes, Give Year or Dates:

College (1-4or 5+)

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes XX No Specify:

14. Raca - American Indien Black, White, etc. White

3 Widowed 4 Divorced 15. Decadent's Education (Specify only highest grade completed)

1 Never Married 2 Married

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

USA

Elementary/Secondary (0-12)

Carpet Mechanic

Contracting

17. Father's Neme (First, Middle, Last)

Clement Louis Klug Jr

18. Mother's Name (First, Middle, Maiden Surname) Mary Alice Knight

19a. Informent's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1229 Ramblewood Road Baltimore, Maryland 21239

Clement Louis Klug III Brother 20a. Method of Disposition 1 Burial XX Cremation 3 Removal from State

20b. Placa of Disposition (Name of cemetery, crematory or other placa) Greenmount Cemetery

20c. Location - City or Town, State 1/30/98 Baltimore, Maryland

Donation 5 ☐ Other (Specify) mature of Funeral Semice Lice

22. Name end Address of Facility

Mitchell-Wiedefeld Home

nnus 23e. Pert1. Enter the disease, or comshock, or heart failure. List only

6500 York Road Baltimore, Maryland 21212 upon that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, base on each line. Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

Grenshot wound of head Due to (or as a consequenca of)

Due to (or es e consequence of):

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last

26. Place of Death (Check only one)

23b. Did tobecco use contribute to the cause of deeth?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings evailable prior to completion of cause of deeth?

1 ¥ Yes 2 □ No

1 Yes 2 No

25. Was case referred to medical examiner? XXYes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation

Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

28b. Time of injury 0602

Other: 4 Nursing Home 5 Residence 6 Nother (Specify)SCENE 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred Subject Sho

1-24-98 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) See W. PATHISCO

ON GRASS BETWEEN TWO APPENT BULLDINGS 29a. Certifier (Check only one)

BALTIMONE CITY 1 Certifying Phyalcien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XX Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier Donald & Wright MD

6 Could not be determined

OCME

29c. License number

29d. Date signed (Month, Day, Year) JANUARY 24, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

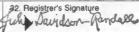
DONALD G. WRIGHT MD

111 Penn Street, Baltimore, Maryland 21201

Registrar

F

31. Date filed (Month, Day, Year) 29 1998



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Constructions - Continue trace and particular way

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Charm, star is ourself

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Virginia LINDLER 26,1998 January 1:50 P.M. /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Franklin Square Hospital Center Baltimore Rosedale If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Funeral Months Days Hours 1□M XXF 71 Yrs. Director 219100672 AUG 27,1926 MARYLAND Usual Residence of Decedent with the Manyland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Med cal Examinar must be notified at 1 ☐ Yes 2 No MD BALTIMORE ROSEDALE Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1210 HILLDALE ROAD 21237 USA permit. Pages 1 and 2 should be filed within 72 hours after death absentment of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or itema 23, any injury or other traumatic event, in Medical Estation and Injury or other traumatic event, in Medical Estation and Injury or other traumatic event, in Medical Estation and Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🖫 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 X Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) OFFICE MANAGER ADVERTISING 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) CHARLES HILSEBERG KIRCHNER MAY 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL CARTER / DAUGHTER ROSEDALE, 1210 HILLDALE ROAD MD 21237 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Suriel 2 ☐ Cremetion 3 ☐ Removel from State GARDENS OF FAITH 1/29/98 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Served Liceon 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTO, MD 21237 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) Madelete . Septicemia 3 days **Examiner** Due to (or es e consequence of) Examiner Pneumonia 1 week Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury Due to (or es e consequence of): Box 68769, Physician/Medical that initiated events Due to (or as a consequence of): 94 resulting in deeth) Lest # 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. å signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, P. Renal failure, congestive heart failure þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? Completed 24a. Was an autopsy performed? Chronic obstructive pulmonary disease law. **page 2** 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Physician: Be 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 this. 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: 1 Naturel Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide after 8 A 24 hours funeral Dir 12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner es stated. edicai 29e. Certifier 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) end menner steted. (Check only one) Within 2 å 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier January 26, 1998

9000 Franklin Square Dr. Baltimore, Maryland 21237 Dr. Stuart Willes 31. Date filed (Month, Day, Year)

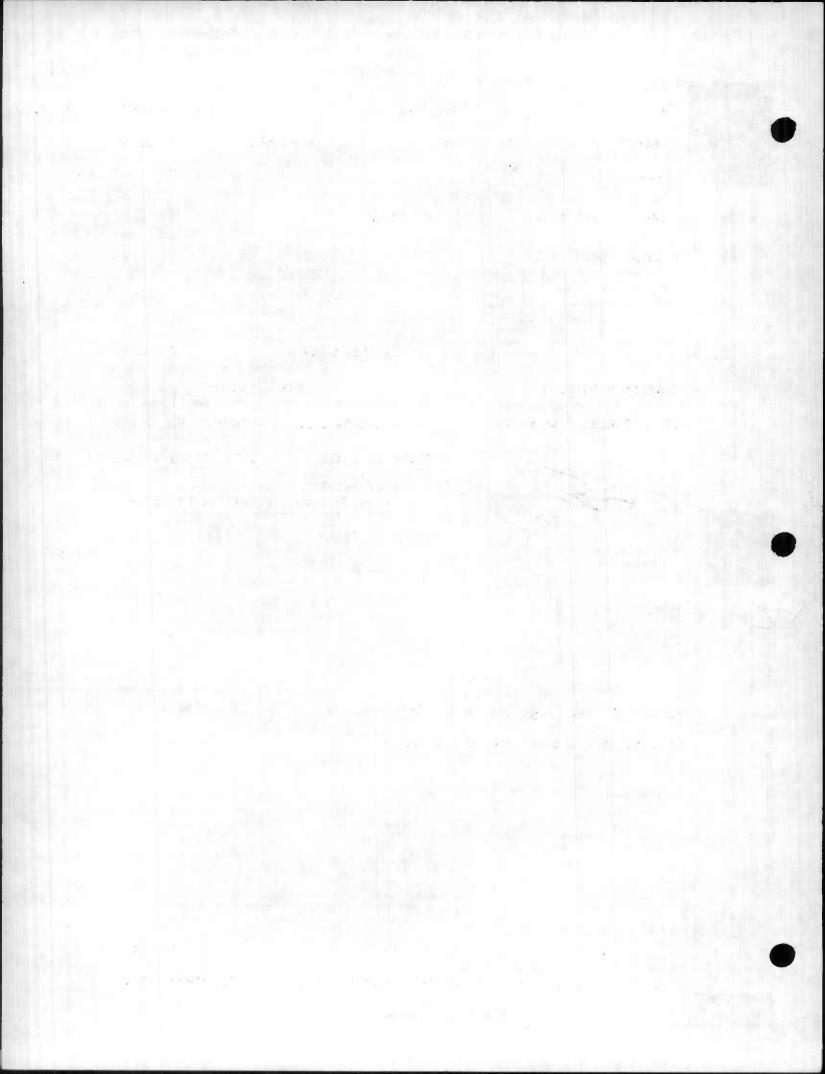
29 1998

JAN

32. Registrer's Signature Maridan Bondall

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Nema (First, Middla, Last) 2. Data of Deeth 3. Tima of Death **Physician** Month Elsie Elizabeth 27,1998 7:30 am Linzey January /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Ivy Hall Geriatric Center Middle River Baltimore If Under 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, 5. Social Sacurity Number 7. Age (In yrs. last birthday) 9. Birthpleca (Stata or Foraign **Funeral** 1□M 2₽F Days Mary land Yrs. 213 34 1445 Director 84 Usual Rasidance of Decadant the Marylend 10h Counts 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yas 2 ☐ No Maryland Baltimore Essex 10e. Straat and Number 10f. Zip Coda 10g. Citizen of What Country? ŏ Items 23a 2630 Linzey Road 21221 USA deeth Funeral 11. Marital Status 12. Was Decedent Evar in U,S. Armad Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Navar Married 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Datas: 0 Baltimore, Maryland 21215-0020 1 ☐ Yes 212 No þ Specify: 3 Wldowed 4 □ Divorced "natural", White Completed 16a. Dacedant's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within Depertment of Health and Mentel Hygiena. Important: If Item 27 is marked other than any injury or other traumatic event Elementary/Secondary (0-12) Collega (1-4or 5+) 6 Housewife Own Home 18. Mothar's Name (First, Middla, Maidan Sumame) 17. Fethar's Nama (First, Middle, Last) Be Walter F. Grammer Josephine Chanev 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) William Walter Linzey (son) 2630 Linzey Road Essex, Maryland 21221 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Gardens of Faith Cem. 1/31/98 Baltimore County, Md 21. Signature of Funeral Service Liver 22. Name and Addrass of Fecility
Bruzdzinski Funeral Home PA 1407 Old Eastern ave Essex, MAryland 21221 of s the causad tha death. Do not antar tha moda of dying, such es cerdiac or raspiratory arrast, as on aach line. Physiclan /Medical Immadiata Causa (Final disaasa or condition resulting in death) . CEREBROVASCULAR ACCIDENT 9 MONTHS Examiner Due to (or as a consequence of): Examiner Sequantially list conditions, if any, laading to immadiate ceuse. Enter Undarlying Cause (Diseasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequance of) Physician/Medical 聖 Dua to (or as a consequanca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.0. 23b. Did tobacco uaa contribute to tha causa of death? Š 1 Yes 2 No 3 Probably 4 Unknown ATHEROSCLEROTIC CARDIOVASCULAR DISEASE signed b Records, þ 24b. Ware eutopsy findings evailabla prior to completion of causa of daath? Completed 24e. Was an autopsy peeu ATRIAL FIBRILLATION, HYPERTENSION ALZHEIMER'S DISEASE 1 ☐ Yes 2 ☐ No certificate 1 Yas 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the tuneral director, 25. Was cesa refarrad to medical axaminar? Be 26. Pleca of Death (Check only one) Hospital: Othar: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Deeth 28b. Tima of 28a. Dete of Injury (Month, Dey Yaar) 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be datermined 3 ☐ Suicide 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 - Homicide 12 Certifying Phyalcian: To the bast of my knowledge, death occurred at the time, dete end piece, end due to the causa(s) and manner as stated. Medical 29a. Cartifiar 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred et tha time, date and place, and due to the causa(s) and mannar stated. 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) D.O. H 35593 JAN. 28,1998 0 30. Nama end addrass of person who sometimed ceuse of deeth (Itam 23a) (Type, Print) DR. JOHN J. LOH 1124 MACE AVE., BALTIMORE, MD. 21221

Ragistrar's Signatura

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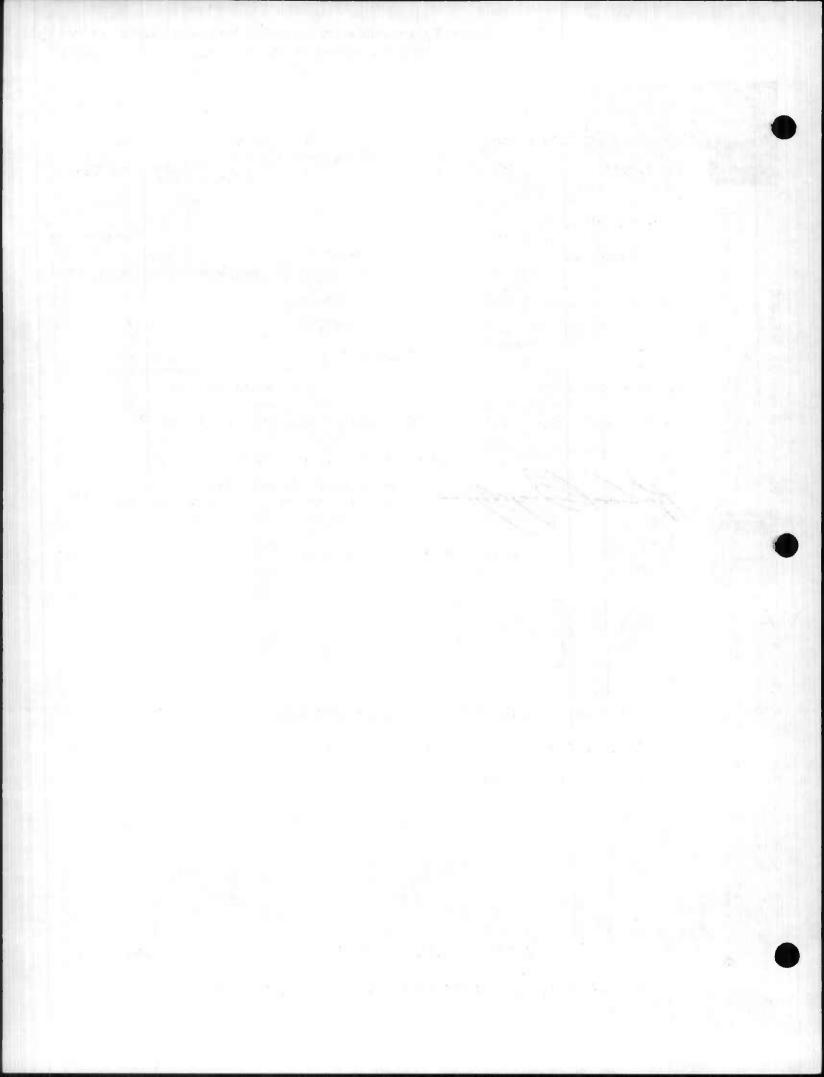
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31. Date filad (Month, Day, Year)

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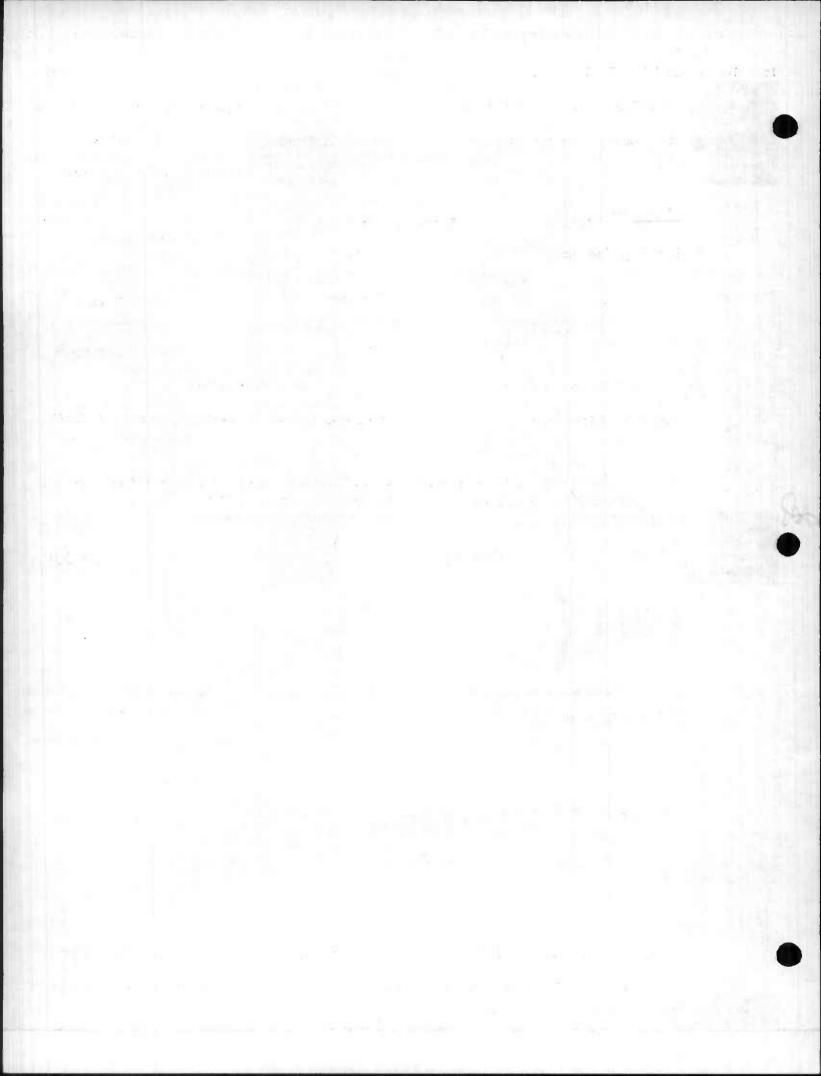


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Item:20b per FH G-755 1/30/98 dh Item:27 per Physician G-755 1/29/98 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month ames NC Aim /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Daath **Examiner** Baltimore Pentland NIA Drive If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 M 2□ F Months Hours 214-12-161 Yrs. Director - 10 - 90 Usual Residanca of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show nothing at Baltimore MD 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò traumatic evant, the Medical Examiner must be U.S.A 230 itams 23a land Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No if Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married Specify: Black Department of Health and Mental Hygiene. Introduce our important: If Nem 27 is marked other than "natural", or i any Injury or other traumatic evant, the Medical Example. Maryland 21215-0020 1 ☐ Yes 2 No p 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry National Gypson Elamantary/Sacondary (0-12) Collega (1-4or 5+) machine operator 6 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meidan Surname) Be McCain Rogers Johnny ula 19a. Informant's Name/Helationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Balto, MD 21206 Williams daughter 4822 Claybury Avenue Baltimore, 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1/31798 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Arbutus, Memorial 22. Name and Address of Facility Joseph L. Russ Funeral Home 2222-28 W. North Avenue, Battimore, MD 21. Signature of Funeral Service Licansee 21216 23a. Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or raspiratory arrest, about, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final disease or condition rasulting in death) Examiner Examiner physician end the buriel-transit be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of) ettending p Part II. Other atgnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Dtd tobacco use contribute to the cause of deeth? 1 ☐ Yas 2 ☐ No 3 Probably 4 ☐ Unknown signed b Records, h 24b. Were autopsy findings available prior to complation of causa of death? should t Completed 24a. Was en eutopsy performed? page 2 s 1 Yes 1 Yas 2 No certificate Division of Vital Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifica etely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residenca 6 ☐ Othar (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 XX Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Straet and Number or Rurel Route Number, City or Town, State) Place of tnjury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicida To the Hospital or within 24 hours eft To the Funeral Dil completely filled in 1 Sartifying Phystotan: To the best of my knowladge, death occurred at the tima, data and placa, and due to the ceuse(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medicai 29b. Signature end title of certifie 29c. Licansa number 29d. Date signed (Month, Day, Year) 30. Name and addrass of person who completed cause of death (Item 23a) (Typa, Print) Good Samar ton Boll , Mb 21237 5601 Lock Roven Blod Duncan Hospital State Registrar

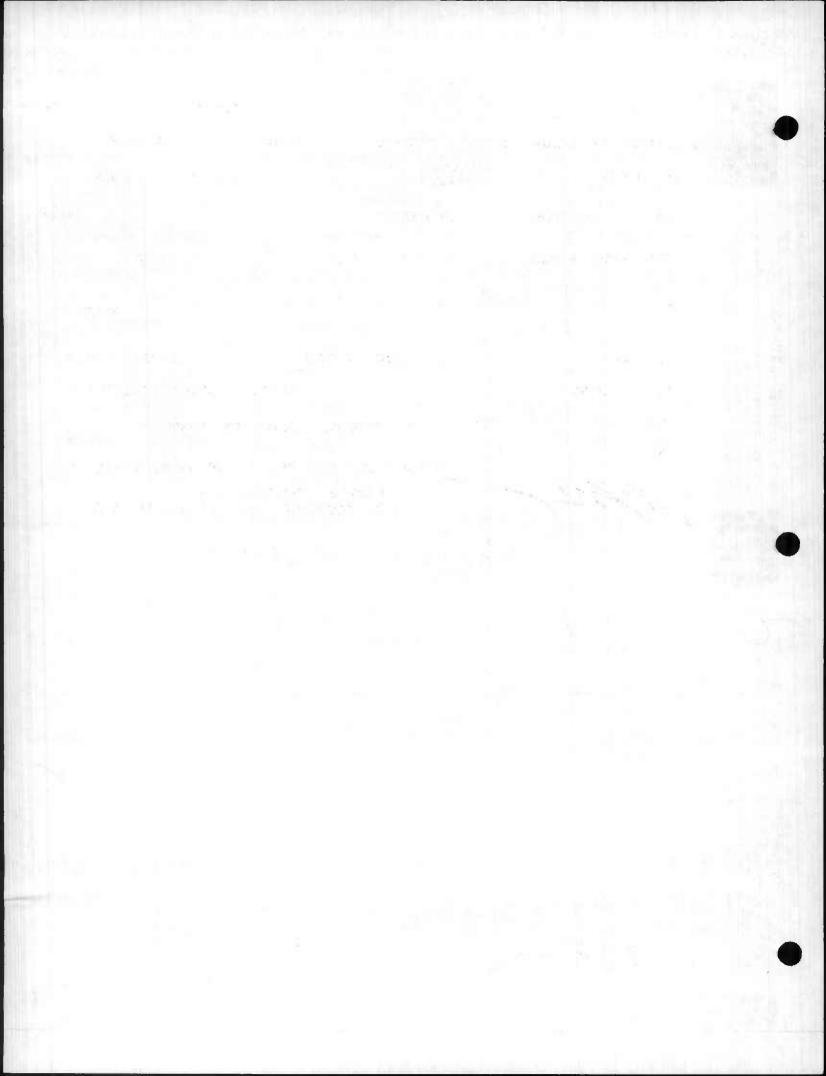
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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene 8 0 2 2 0 7

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Departmen Important: eny injury once.		21. Signatura of Funaral Sarvice Licer	isee 7	2		Nama and Addr					,
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth servandine M. McKenNA VANUARY 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Church Hospital Baltimore N/A 6. Sex 7. Age (In yrs. last birthday) if Under 1 Year if Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplece (State or Foreign Country) Deys Yrs. 215-30-6591 December 18,1933 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes AXX Maryland Baltimore Parkton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 9 Lantern Circle 21120 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes X XIX o if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Reca - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes XXXNo Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Proof Reader Retail Store 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) John William McKenna Helen Margaret Moran 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy P. McKenna 4129 Roland Avenue Baltimore, Maryland 21211 Nephew 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 1/28/98 Baltimore, Maryland Greenmount Cemetery ignature of Funeral Service Licensee 22. Name end Address of Fecility Mitchell-Wiedefeld Home 6500 York Road Baltimore, MAryland 21212 23a. Pert1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Onset end Death · Metastatic Cancer of Uterus Immediate Ceuse (Final disease or condition resulting In death) Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cerebrovascular Accident 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 Yes 200 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Recoller Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28c. injury et Work? 28b. Time of 28d. Describe how injury occurred

68760 Physician/Medical Box P.0. Records, Division of Vital Be 70 this Ather Attending ours after dean.

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altimore, Maryland 21215-0020

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25. Wes case referred to medical exeminer? 1 ☐ Yes 2 X No 27. Menner of Deeth 5 Pending Investigation 1 DNatural 2 Accident 6 Could not be 3 Suicide 4 ☐ Homicide

29a. Certifier 29b. Signetyre end title of certifier

Registrar

Medical

28e. Piace of Injury - At home, farm, street, factory, offica building, etc. (Specify) 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and place, and due to the ceuse(s) end manner stated.

A. R. Muzemi mo

1 Yes 2 No

29c. License number 29d. Dete signed (Month, Day, Year) D(7322 TAN, 26, (995)

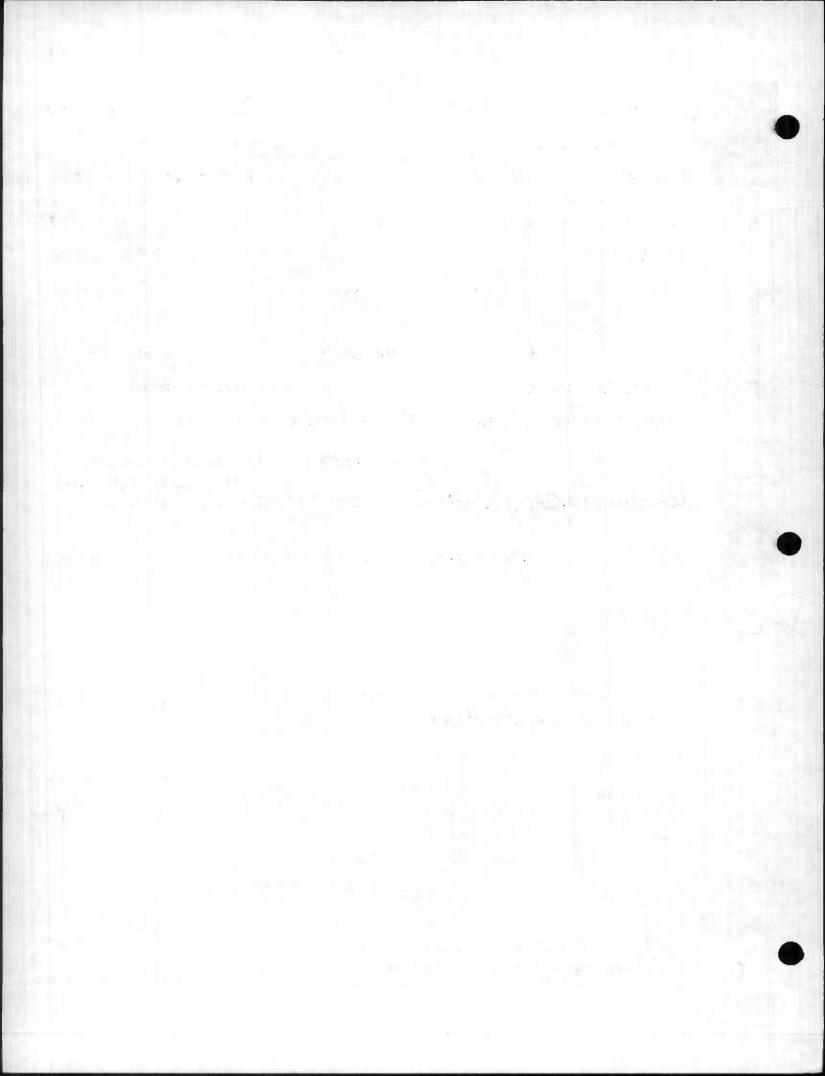
28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

P. NALEMI, ND, CHURCH HOSPIFAL, BALT. MD. 21231

31. Dete filed (Month, Day, Year) 29 1998 22. Registrer's Signeture ruh Davidson-Randall

To the Hospital or within 24 hours at To the Funeral D



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Nicholison Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month 10:15 PM E. Nicholson Lerov 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death NA Union Memorial Hospital Baltimore 5. Social Security Number 6. Sax If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 1 XM 2 F Days Hours Yrs. 60 217-40-9684 Usual Residence of Decedent 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore XX Yes 2 No Md NA 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21218 USA Street Apt. #70 11 West 20th 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, spacity Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Nevar Married 2 Married 1 ☐ Yes 2 € No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Machinist MD. Drum Co. 9th Grade 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Elsie Nicholson Wison Roy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2021 Robb Street Baltimore, Maryland 21218 Elsie Richard 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Md. Nat'l Cem. 01-30-98 Laurel 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility Baltimore, Maryland 21202 of Funaral Sarvice Licensea WM.C.March FH 1101 E. North Avenue nter the disease, or complications that caused tha death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, rheart failure. Approximata Interval Between Onset end Death Immediate Cause (Final Hemorrhage diseese or condition resulting in death) Due to (or as a consequence ot) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of): Dua to (or as a consequance of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deeth Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturel 1□Yes 2□No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Physician /Medical Examiner 68760 8 P.O. Box Records. of Vital Division

the The law requires that the death certificate se esn ete hes been signed by page 2 should be detect or Attending Physician: efter death.

Director: After this certific d in by the funeral director, To the Hospital of within 24 hours of To the Funeral D completely filled Leroy

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f show any injury or other traumatic event, it a Marinal Examiner must be nuttled a gones.

Baltimore, Maryland 21215-0020

State Registrar

31. Date filed (Month, Day, Year)

29a, Certifier

29b. Signatura and title of certifier

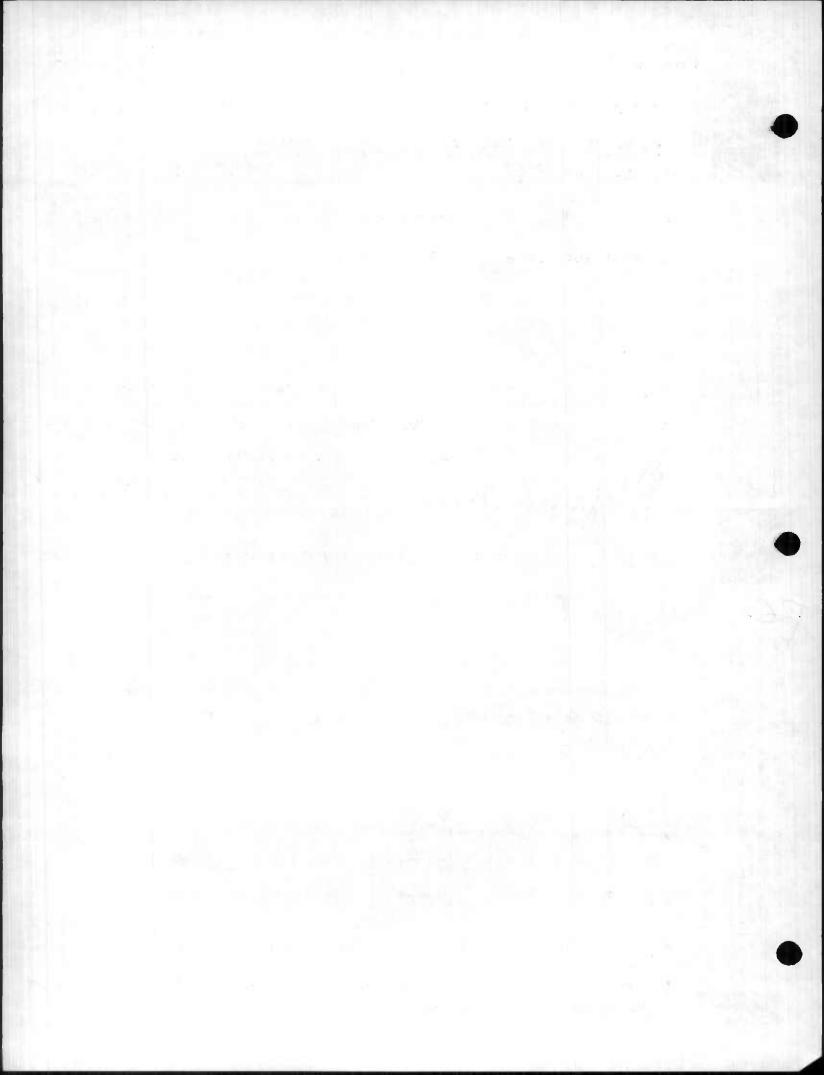
29c. License number

29d. Date signad (Month, Day, Year)

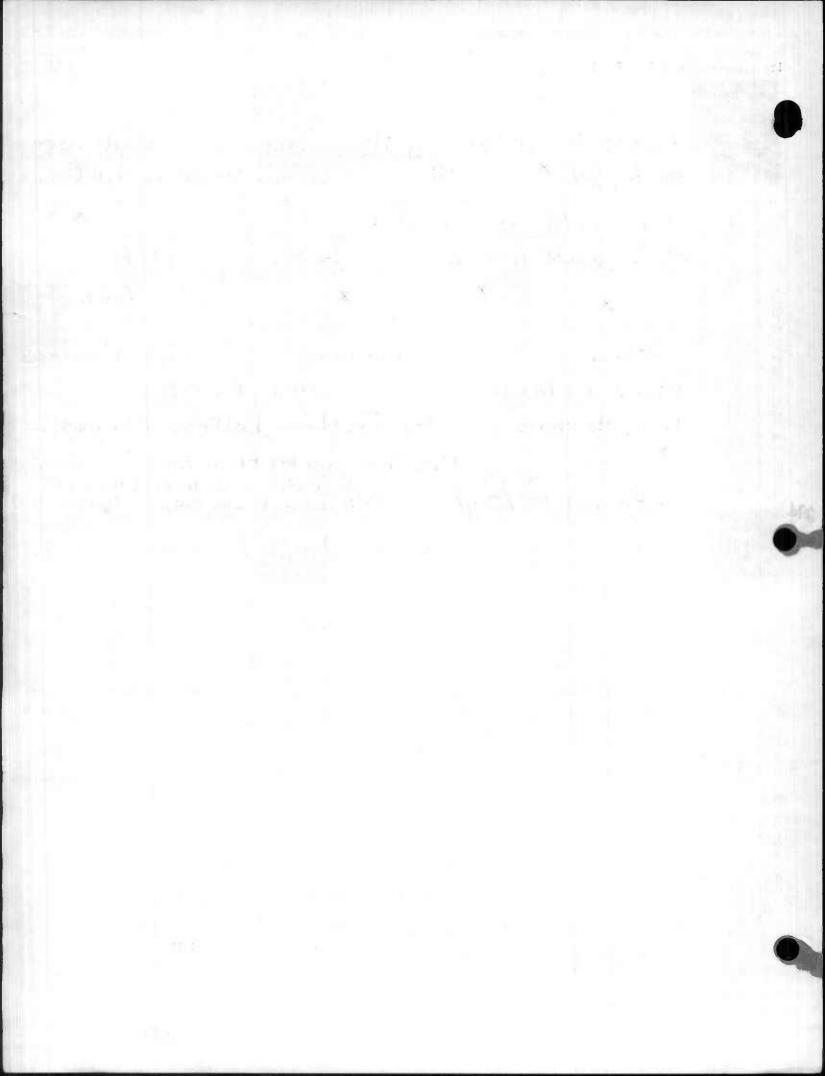
30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

N Charles St, S216 Baltimore, Md 21204 Spar, MD Brian 6565 62. Registrar's Signature whi Davidson

🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.



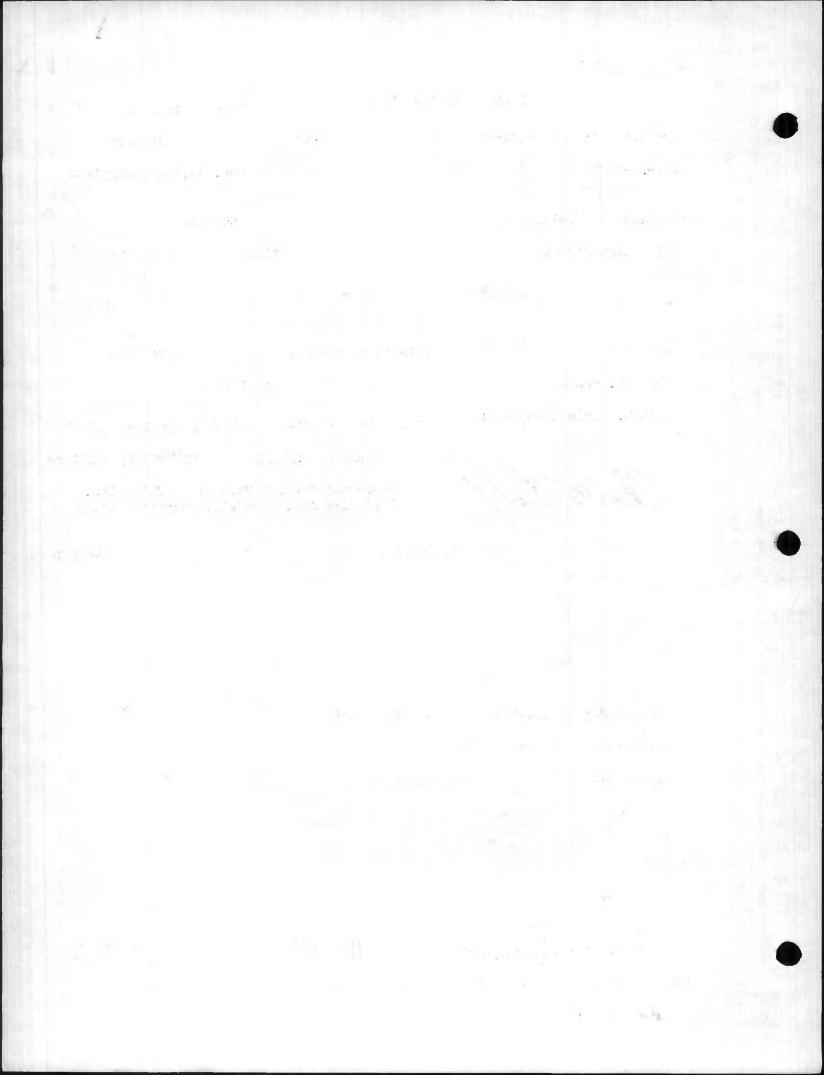
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/Medical Examiner Funeral Director	5. Sc	13-42-0709	en Nurs		me Balter 1 Year if Under 24 Hr	Location of Deeth		of Deeth atin	nore State or Foreign
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0020 rours after de ural, or frem	3	Marritel Status ☐ Never Married 2☐ Married ☐ Widowed 4 Divorced	12. Was Decedent Ever In U Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:	1 ☐ Yes	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue		Black	- American Inc. White, etc.	lian,
Maryland 21215-0020 d.2 should be filed within 72 hours aft th and Mental Hygiene. 7 Is marked other than "natural, or traumatic event, the Medical Examp To Be Completed by F	EI	15. Decedent's Edi (Specify only highest grade ementary/Secondery (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of a life. DO NOT	ual Occupation work done during most of was retired)	orking	6b. Kind of Bus	Siness/Industry Bus	iness
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Baltimore, N permit. Pages 1 and Department of Health Important: if Item 27 any injury or other tr	21.	4 Donation 5 Other (Specify, Signature of Funeral Service Licens	O. Bouki	2140	Cemetery and Address of Facility ph H. Bron N. Fulton	tremue D	ineral	Home Mary	lava ortol
Physician /Medical Examiner	Imm	Part1. Enter the disease, or comp shock, or heart failure. List only o ediete Ceuse (Final ase or condition Iting in death)	RECURRED	NT As	PIRATION	ec or respirator) arre	st,	Appri Interv Onse	oximate al Between t and Death
executed no end intransit Examiner	Seq	ventially list conditions,	b	or es e consequenca o					
8760 ate be hysicia the bur	resu	ventially list conditions, y, leading to immediate re. Enter Underlying se (Diseese or Injury Initiated events Iting in death) Last	c. Due to (o	r as a consequence of):				
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in partie	3	B Suicide 6 Could not be determined	28e. Plece of Injury - At he building, etc. (Specify	ome, farm, street, factory)	ory, office	28f. Location (Str. City or Town,		r or Rural Rout	e Number,
To the Hospital within 24 hours a To the Funeral Completely filled	29a.	Certifier (Check only one) CertifyIng Phy 2 Medical Exami	sician: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, death occurre tion and/or Investigetion	d et the time, date and place, in my opinion, deeth occ	a, and due to the ca curred et the time, da	use(s) end man te and place, er	ner as stated. nd due to the co	ause(s)
To the comple	29b.	Signature and title of certifier	<u> </u>	2	9c. License number	29	d. Date signed	(Month, Dey, Y	(ear)
		Jasuen	Lellham		1) 285 31	1	-11-98		
-	孙	SNEEM (AK	empleted cause of death (Item	23a) (Type, Print)	HEICHT	AVE B	AUTO A	11) 2/2	08.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Eleanor Barbara Oltman 6:55 PM January 15, 1998 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year)
Dec. 24,1927 5 Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 20 F Days Hours 214-22-5488 Director 70 Yrs. Maryland Usual Residence of Decedent the Meryland 10a. State 10b. County "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Baltimore Dundalk 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? filed within 72 hours after death with 7216 Gough Street 21224 United States Funerai 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 21215-0020 Completed by 1 ☐ Yes 2 No Specify. Specify 3 Widowed 4 □ Divorced White traumatic event, tre Wed cal 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Substitute Teacher Education marked other Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 end 2 should be finent of Health end Mental I int: If Item 27 is marked or Elmer C. Koutz Hazel Frye 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Peges 1 end 2 a Department of Health er Important: If Item 27 is any Injury or other trau Hazel M. Davis (Daughter) 8135 Plowden Drive LaPlata, Maryland 20646 of Disposition (Neme of Date 20c. Location - City or Town, Stete 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Baltimore, Maryland Oak Lawn Cemetery 1/19/98 4 ☐ Donation 5 ☐ Other (Specify) miral Service License 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222
Approximate the mode of dvino. such as cardiac or respiratory errest, 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respi shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediete Ceuse (Finel 48 Have disease or condition resulting in deeth) **Examiner** Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequenca of): Box 68760. Physician/Medical Due to (or as e consequence of) The law requires that the death certificate 80 for use s certificate has been signed by the e director, page 2 should be detached for Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. o 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown OVARIAN Records. Be Completed by 24b. Were eutopsy findings eveileble prior to completion of cause of death? COLITIS 24e. Wes an autopsy performed? COPD 1 ☐ Yes 25 No 1 ☐ Yes 2 ☐ No this certificate Division of Vital or Attending Physician: 25. Wes case referred to medical exeminer? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After 5 Pending Investigation 1 DNatural 1 ☐ Yes 2 ☐ No death. 2 Accident efter deatl in by the 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours e To the Funeral D 29a. Certifier 1 Scertifying Phyelcien: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, In my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Name end eddress of person who co pleted cause of deeth (Item 23e) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 29 1998

NATHAN M ROSENBLUM 7600 CSCER DRICE TOWN MID 32. Registrer's Signature



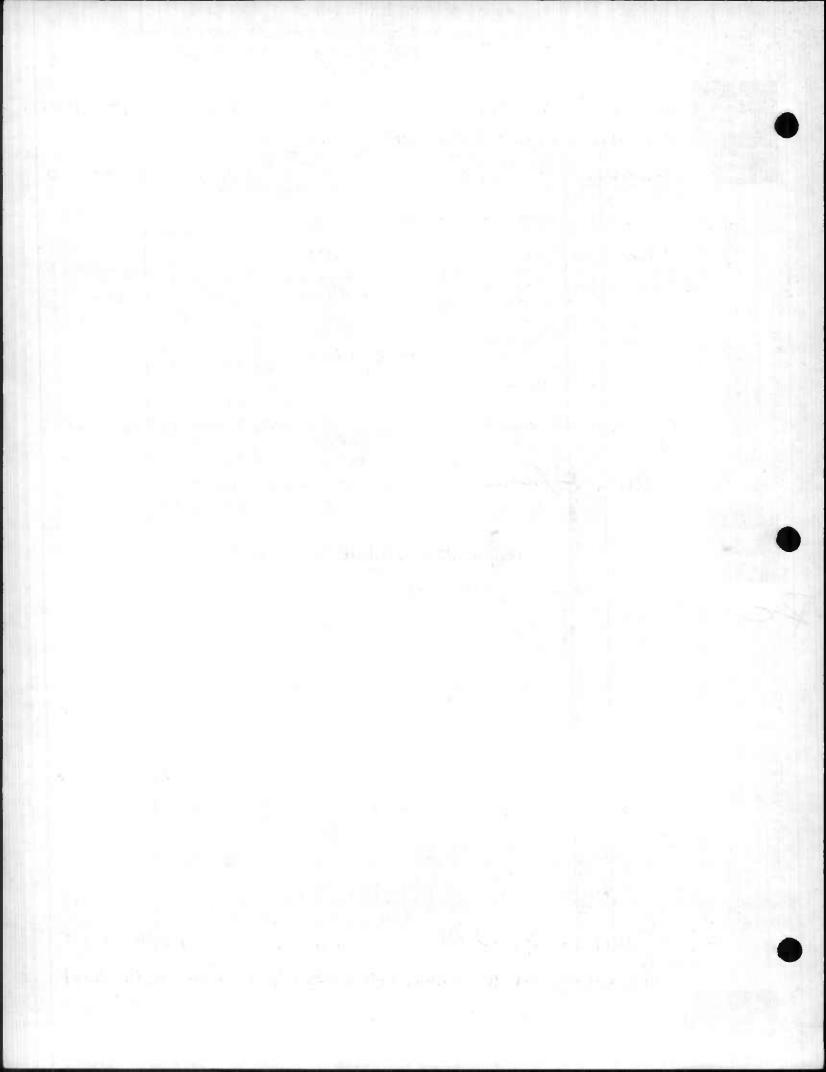
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name /First Middle Last 2. Dete of Death 3. Time of Death Month **Physician** James J. O'Brien 07:10 PM 98 Jan 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore N/A

9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 □ F Director 086-14-2594 3, 1909 Massachusetts death with the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore County Rodgers Forge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 Parliament Court 21212 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or iten any injury or other traumatic event, tra Medical process. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Banking 5+ Investment Banker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Daniel O'Brien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Virginia O'B. Stacey, (Dghtr) 41 Parliament Court, Baltimore, Maryland 21212
20b. Plece of Disposition (Name Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 1 X Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 1/27/98 Newark, New Jersey Mt. Olivet Cemetery 21. Signatur of Funerel Service Lin 22. Name and Address of Facility Mitchell-Wiedefeld Home, Inc. Martin D. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, Approximate shock, or heart failure. List only one ceuse on each line. Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 physician Physician/Medical ĝ Due to (or as a consequence of) 88 attending 985 ed by the a detached t P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detact 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Yunknown Records. by 24a. Wes en autopsy performed? 24b. Were autopsy findings available prior to Completed peed completion of cause of death? has Page 2 1 ☐ Yes 2 X No 1 ☐ Yes 2 No cartificate Division of Vital 25. Was case referred to medical 26. Plece of Death (Check only one) Hospitel: 1 Sunpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ž unera 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending Investigation 1 MNatural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

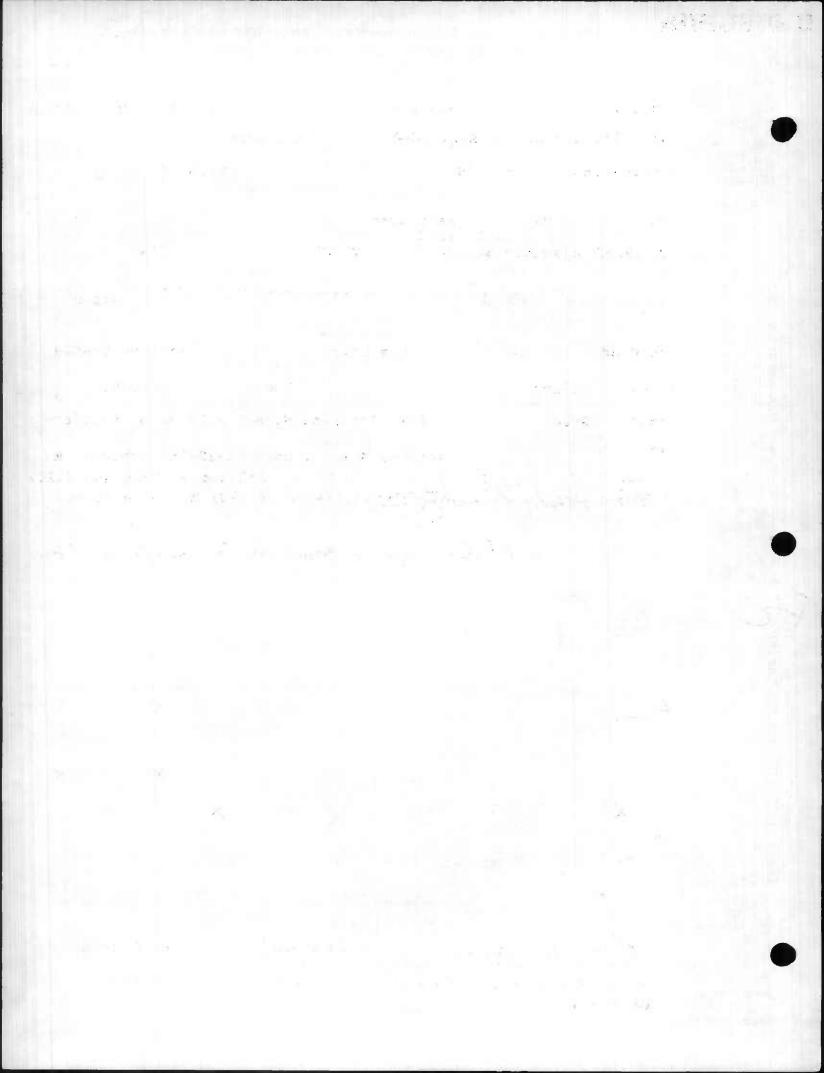
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. cai 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) et van Egmond MD 123/98 P11339 OW and address of person who completed cause of death (Item 23a) (Type, Print) Juliet van Egmond MD, JHBMC, 4940 Eastern Avenue, Baltimore, MD 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature ut Davidson-Randall JAN 29 1998 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q

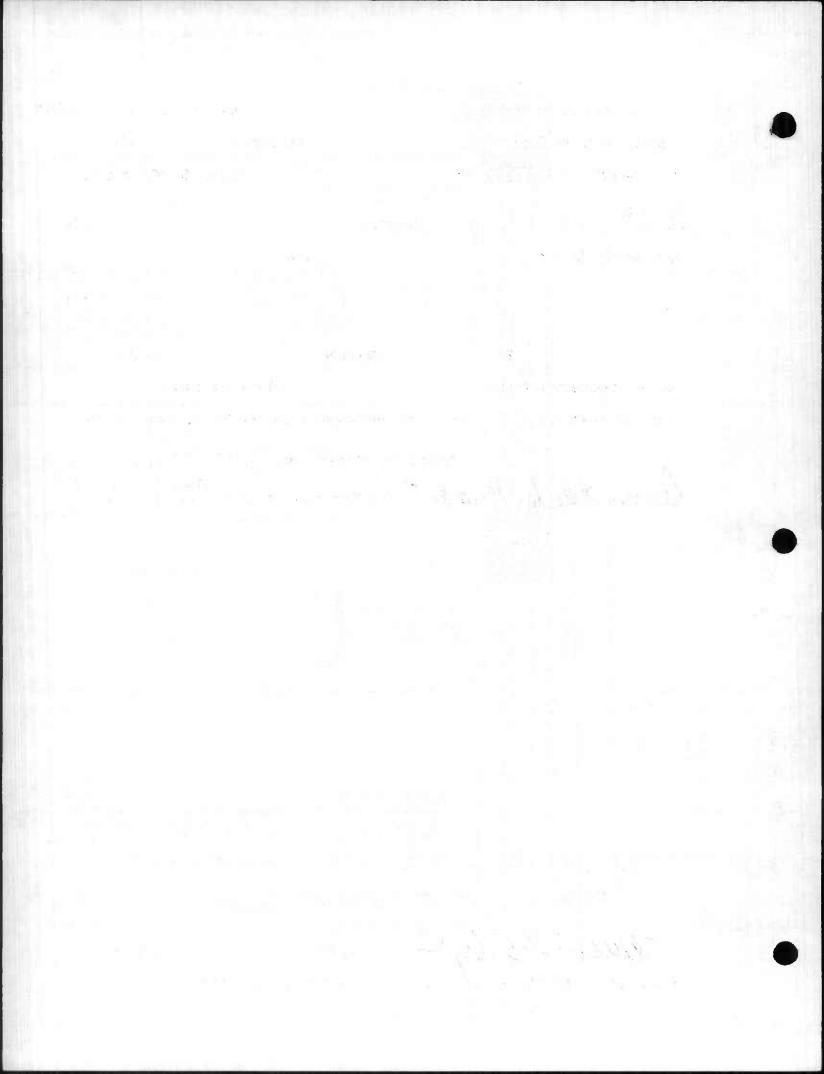
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/Medical	Myrtle		Pickins	3		Jan.		Yeer 98	6:35p
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Examiner	633 Aisquith		pt. 18-3	J	Baltimo	ore	NA		
Funeral Director	5. Social Security Number 6. S 219-30-1180A	D	9 (In yrs. lest birthde	Months Deys		8. Date of Birth (Month, Dey 09-13	-18	9. Birthple Countr	
show	Usual Residence of Decedent 10a. Stete 10b. County		10c. City, Town or	Location				10	d. Inside City Lir
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23a or 28 unit be no ral Dire	10e. Street end Number 633 North Aisc	_	#18H eet	10f. Zip Code 21.20	2	1	0g. Citizen of W	het Countr	ry?
ar, or items traminer m by Funer	11. Maritel Status 1 □ Never Merried 2 □ Merried 3 ☑ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 If Yes, Give Yeer or Dates:		3. Wes Decedent of If Yes, specify Cult	Hispenic Origin? (Spean, Mexican, Puerto Specify:	pecify Yes or No- Ricen, etc.)		- Americe , White, et	tc.
natura edica leted	15. Decedent's Ed (Specify only highest gra Elementery/Secondary (0-12)	fucetion ide completed) College (1-4or 5	(Gi	cedent's Usuel Occu ve kind of work done . DO NOT use retire	pation during most of work d)	king	16b. Kind of Bus	iness/Indu	ustry
omp	8th Grade	NA		omestic			variou	s tr	ades
\$. o	17. Fether's Neme (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sumeme)	
7 is marked of traumatic ever	Frank Wilso		19b Ma	illing Address (Stree	Zudie		Bro City or Town. S		Code) 212
6	Dreece Green	***			ou Stree				
if itsm 27	20e. Method of Disposition		20b. Plece of Dis	position (Neme of		Dete	20c. Location - C		-
y or o	1 Department 2			remetory or other pla us Mem.P		01-29-			ıs, Md
important: any injury	21. Signature of Funeral Service Licen	see bl		22. Name and Addr	De	altimor			
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s been signi 2 should be pleted by						24e. Wes e	en eutopsy med?	eva con	re eutopsy findi ilable prior to apletion of ceus eeth?
page page						1 🗆 Y	es 2 No	1 🗆	Yes 20 No
certificate rector, pay	25. Wes case referred to medical				26. Plece of Dee	th (Check only or	те)		
H 10	exeminer? 1 ☐ Yes 2X No	Hospitel: 1 ☐ Inpatie	nt 2□ ER/Outpet	ient 3 DOA	ther: 4 Nursing H	ome 5 Resid	ence 6 Othe	r (Specify,)
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al Director: Aher it ed in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injubuilding, etc	ury - At home, larm, c. (Specify)	street, lactory, office		28f. Location (S City or Tow	treet end Numbe n, Stete)	or Aurel	Route Number,
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To the Funeral Director: completely filled in by the Medical Certifical	29b. Signeture end title of certifier			29C. Licer	ise mumber			,	Jey, Year)
Funer dely fill lical	10 1	remberger, h	-0		3-001		Jan. 27		



State of Maryland / Department of Health and Mental Hygiene

		4 Decedents Name /First Middle /				rtificate	, 0, 1	204117		leg. No.		
hysicia	n	Decedant's Nama (First, Middla, L							2. Data of Dea Month	Day	Year	. Time of Death
/Medic		Elizabeth Gow							January			9:35AM
xamin	er	4a. Facility Nama (If not institution, g.	iva street and numbe	er)			4	b. City, Town, o	r Location of Death	4c. County	of Death	
		5011 Broadmoor	Road					Baltir			N/A	
neral			Sex 7./	Aga (In yrs.	last birthday)	Months 1	1 Yaar Days	If Undar 24 Hr Hours Mir		Year)	9. Birthplace	(Stata or Fore
ector		215-50-0634 Usual Rasidance of Decedant	10 M 20 F	89	Yrs.				February	14,1908	Alask	
E III		10a. Stata 10b. County District of		10c. Cit	y, Town or Lo	ocation						Inside City Limi
CITIES	5	Columbia N/A		1	Washin	aton						1 Yas 2 1
700	ire	10e. Street and Number				10f. Zip C	Coda		1	l 0g. Citizan of V	What Country?	
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5	Funeral Director	11. Marital Status	12. Was Decedar Armed Forcas	nt Evar in U	,S. 13.	Was Deceda			Specify Yas or No- irto Rican, atc.)		e - Amarican I	ndian,
	à	1 Navar Married 2 Married 3/12 Widowed 4 Divorced	1 Yas X2	XNo		1 ☐ Yas X 🎢		Specify:	no Hican, atc.)	Specify	ck, Whita, atc.	ite
Sal.	Completed	15. Dacedant'a E	Education		16a. Dece	dent's Usual	Occupa	ition		16b. Kind of Bu	usinass/Indust	ry
Med	Be	(Specify only highast gi	rada completed) College (1-4o	v. 5.1)	(Giva	Not work DO NOT use	k dona d a retired	uring most of w	orking			
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ent,	Bec	17. Fathar's Nama (First, Middle, Las	st)					18. Mothar's No	ame (First, Middle,			
0	ToB	James Bartholom	ew Gowen					Hele	ene Burli	nson		
	-	19a. Informant's Name/Ralationship			19b, Maili	ing Addrass ((Street a	-	Rural Routa Numbe		Stata, Zip Co	de)
5	1	James Gowen Prat		Son					Baltimore			
other tr	- 1	20a. Method of Disposition				osition (Name matory or oth				20c. Location -		
6	-	1 \$ Burial 2 □ Cremation 3 I	☐Removal from Stat	100							THE PARTY AND	
injury	- 1	4 Donation 5 □Other (Spec	100	Ar	The second second		ALCOHOL: NAME OF TAXABLE PARTY.		1/29/98	Arlingt	on, Vi	rginia
any ir		21. Bignature of Funeral Service Lice	noon No	/	/ 2	2. Name and	Addres	s of Facility	Mit	chell-W	iedefe	Id Home
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liner		resulting in death)	a Fileu		L L INCOME						-	
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth JANUARY Dey 26 **Physician** RMA 10 27 PM /Medical 4b. City, Town, or Location of Death 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner CENITER MALTIMORE HOSPITAL HARBOR N/A | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | JAN. 10 1943 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F MARYLAND 55 Yrs Director 218-34-5446 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23s or 28s-f show other traumstic event, the Medical Examiner mast be notified at 1√Xes 2□No Director MARYLAND N/A BALTIMORE CITY 10e Street and Number 10g. Citizen of What Country? permit. Pages 1 end 2 should be filed within 72 hours effer death w. Depertment of Health end Mental Hygiene.
Important: If item 27 is marked other than "naturel", or items 23a any injury or other traumatic event 831 SEAGULL AVENUE APT A1 21225 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 XXVo If Yes, Give Year or Dates: 1 ☐ Yes 2 Tho Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) BUSINESS SECRETARY/RECEPTIONIST 12th grade 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) JAMES HOLLEY IRMA P. ROBINSON.I 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Stephanie Robinson/ 1005 Bethune Road, Baltimore Maryland 21225 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State KING MEMORIAL PARK 2-3-98 BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Fund 22. Name end Address of Fecility WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE exelle Pel Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical SEPTICAMIA Immediate Cause (Finel diseese or condition resulting in death) Examiner Due to (or as e consequence of): Examiner Due to (or as e consequence of): INFELTION Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest NEPHRO PATTHY Physician/Medicai physic Due to (or es e consequence of): the as 2 YEARS AIDS 9SC 23b. Did tobecco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 | Yes 2 | No 3 | Probably 4 | Unknown by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 Yes 2 UNO funeral director, 25. Was case referred to medicel exeminer?

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Box 68780 Records, P.O. peen certificate Division of Vital Hospital or Attending Physicien:
 24 hours efter deeth.
 Funerei Director: After this certific.

the Maryland

Baltimore, Maryland 21215-0020

29a. Certifier

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end manner stated. (Check only one) 29b. Signeture end title of certifier

RESIDENT , MEDIENE

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number AS 2441614-19

MD 21225

29d. Dete signed (Month, Dey, Year) JANUARY 26, 1998

30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) 3001 SHANOVER ST BATTIMORE

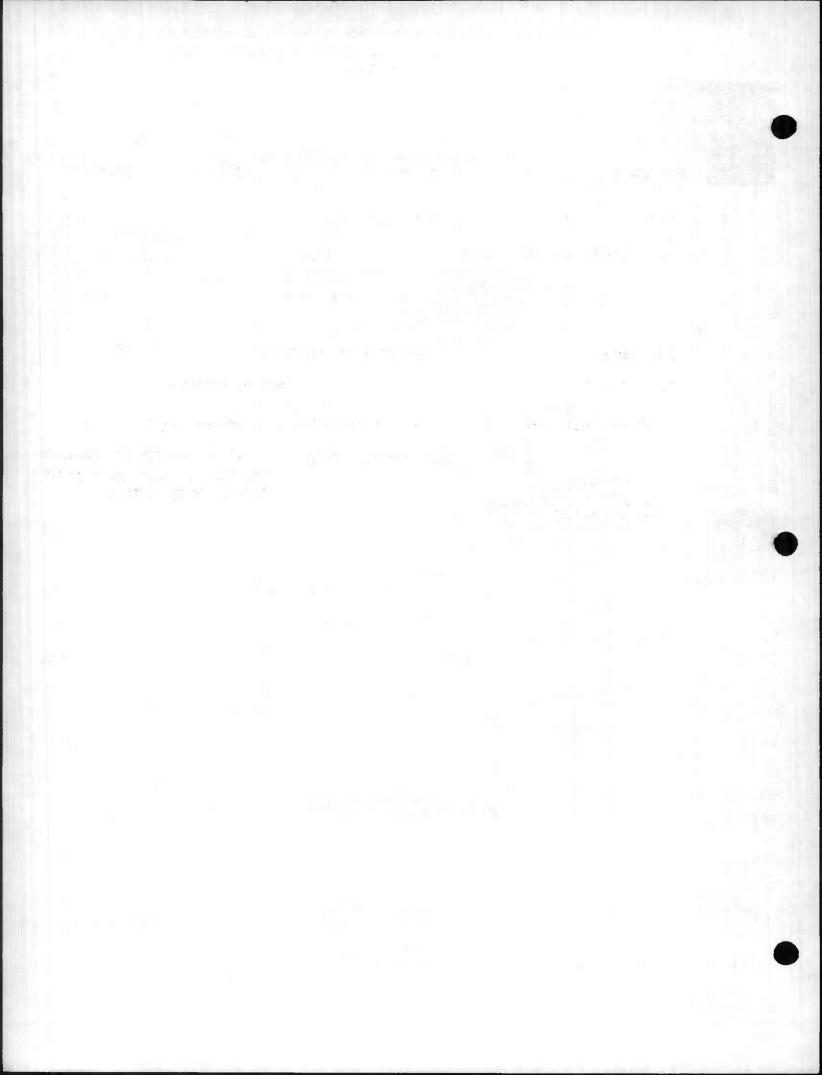
BINU CHACKO 31. Dete filed (Month, Dey, Yeer)

2. Registrar's Signeture

State Registrar

Medical

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State of Maryland / Department of Health and Mental Hygiene 98 022 | 6

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AMATUM NA NA EEM 501 DO PHIN Street, Baltimore Mo		;	O. Name end address of person who AMMUA H	completed cause of c	leath (Item 23	(Type, Pr	PHI	N stre	et, Bo	Itimo	re M	10 21

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death LILLIAN ROSEN BEIGER 2 8 Month 01 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE BALTIMORE SHOOK TRAUMA UNIV MARYLAND 7. Age (In yrs. last birthday)

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9. Birthplece (In yrs. last bi 5. Social Security Number 9. Birthplece (State or Foreign 1 M 2 F 215-14-5562 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Carroll Millers Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4747 Schalk Rd. #1 21102 U.S.A. 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack. White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home Maker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Martha Foose Jacob Anderson 19a. Informant's Name/Retationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) P.O. Box 1100, Westminster, Md. 21158 Mark Rock 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Good Shepherd Cem. Jan. 30, 1998 Ellicott City, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme end Address of Fecility
Eckhardt Funeral Chapel
3296 Charmil Dr. Manchester, Md. 21102 21. Signature of Funeral Service Licenses . Harth Eeslan 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Finel 5NTRACEREBEAL diseese or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? t ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings eveitable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yes 2. No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at

d 2 should be filed within 72 th and Mental Hygiene.

permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or other trau

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Baltimore, Maryland 21215-0020

Examiner Box 68760. Physician/Medical 9 Records, P.O. ď by Completed Division of Vital

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Medical Certification:

Registrar

25. Was case referred to medical 1 Yes 2 No 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending 1 Naturat 01-24.98 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 4747 Smalk 12 #1 Hillers, Md 29a. Certifier Certifying Phyelcfan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signeture end title of certifier George W Determanky 051 50/

29c. License number

29d. Date stgned (Month, Dey, Yeer)

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

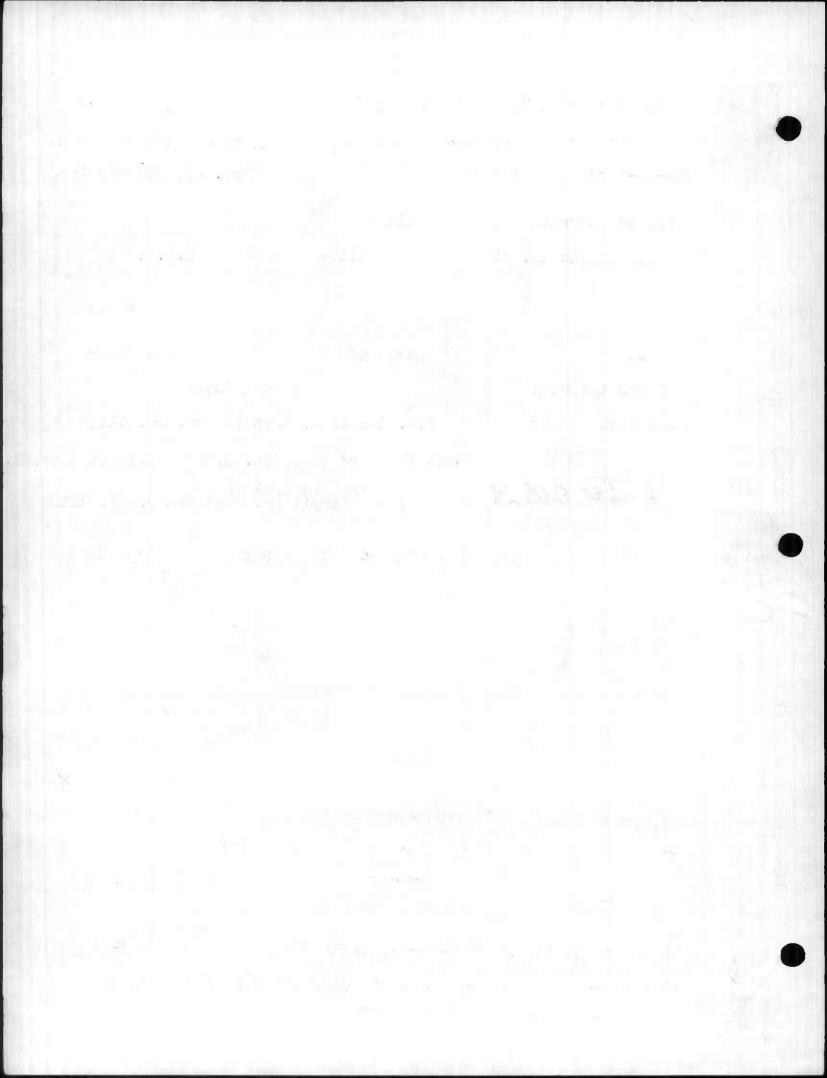
SouTH GREENEST BALTIMOTE MNIV of MARYLAND

31. Dete filed (Month, Day, Year) JAN 29 1998

(Check only one)

32. Registrar's Signature

Juna Davidson Andale



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Donald W. Rice Month January 23 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Liberty Medical Center Baltimore if Under 1 Yaar If Undar 24 Hrs. 5. Sociel Security Number Birthpleca (State or Foreign Country) Md 7. Age (In yrs. lest birthday) XXM 2 F Deys 220-36-7135 Yrs. 57 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No NA Baltimore 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 1101 North Collington Ave. 21213 USA 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Black 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6th Grade NA Housekeeping Johns Hopkins Hosp 17. Fether's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Charles Rice 19a. Informent's Name/Relationship (Typa, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Md. 21213 Rice 1101 E. North Collington Avenue Baltimore, 20b. Place of Disposition (Name of cematery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Purial 2 ☐ Cremetion 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Arbutus Mem. Pk. Cem. 01-29-98 Arbutus, Md. 21. Signature of Funerei Sarvica Licensaa 22. Name end Address of Fecility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Immediate Cause (Final disease or condition resulting in death) Metastatic Prostate Cancer auge Right Sequentially list conditions, if eny, leading to immadiete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 2 No 212 No 25. Wes case referred to medicel

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health end Mentel Hy Important: If Item 27 is marked other any Injury or other traumatic event once.

Physician

/Medical

Examiner

10e. State

Funeral

Director

28a-f show

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items 23a

e filed within 72 hours after death vel Hygiene.

Maryland 21215-0020

Baltimore,

Director

Funeral

þ

Completed

Be

traumetic evant, the Medical Examiner must be notified at

the Maryland

physician s the burta Box 68760 Division of Vital Records, P.O. certificete

Physician/Medical ò Completed Be 2 Certification:

or Attanding Physician: The law requires that the death certificate be After this within 24 hours after death.

To the Funeral Director: A completely filled in by the ft

> State Registrar

Medical

30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) George E (Wicks The MiD),

5 Pending investigation

6 Could not be determined

Dills III M.D.

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

1 ☐ Yes 2 ☐ No

28c. Injury et Work?

🖆 Certifying Phyaician: To the best of my knowledge, deeth occurred et tha tima, dete end place, end due to the ceuse(s) end menner es steted.

2 Madical Examiner: On the basis of axamination end/or invastigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Numbar, City or Town, Stete)

January 23, 1998 2600 Liberty Keights Ave. 21215

28d. Describe how Injury occurred

George E. 31. Date filed (Month, Day, Year) JAN 29 1998

exeminer?

1 Yes

27. Menner of Deeth

1 Neturel

2 Accident

4 Homicide

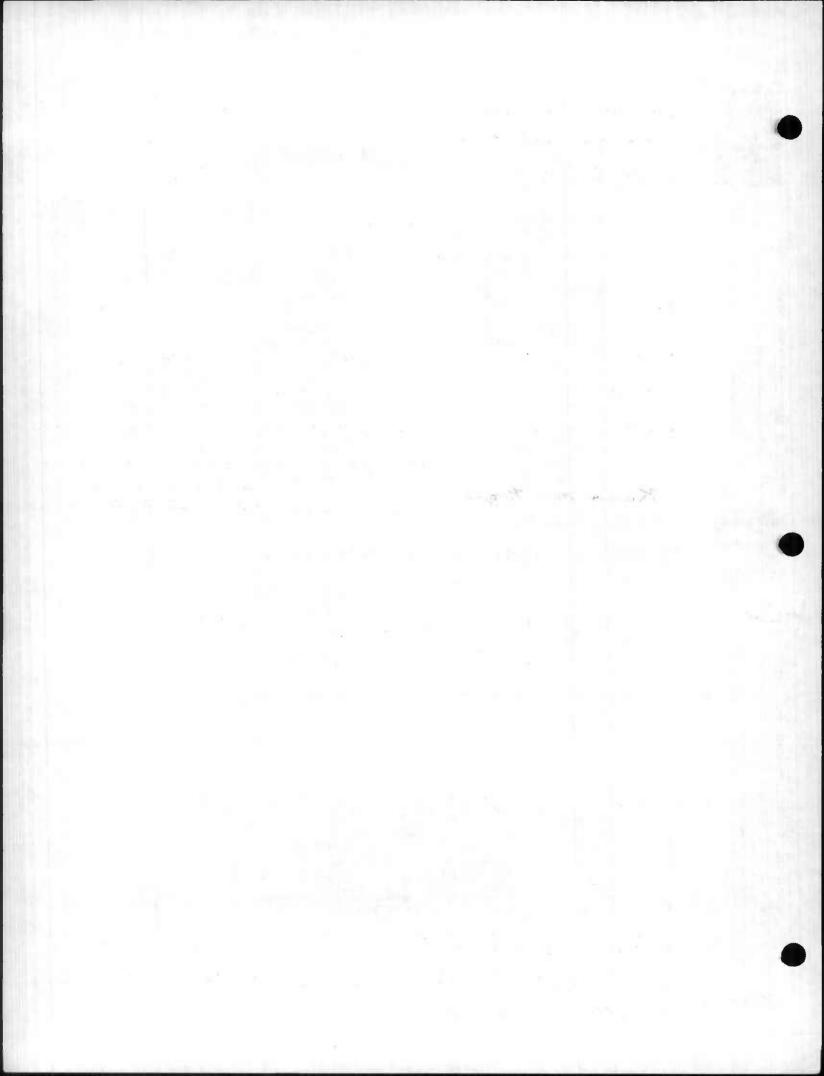
3 ☐ Suicide

29a. Certifier (Check only one)

2 No

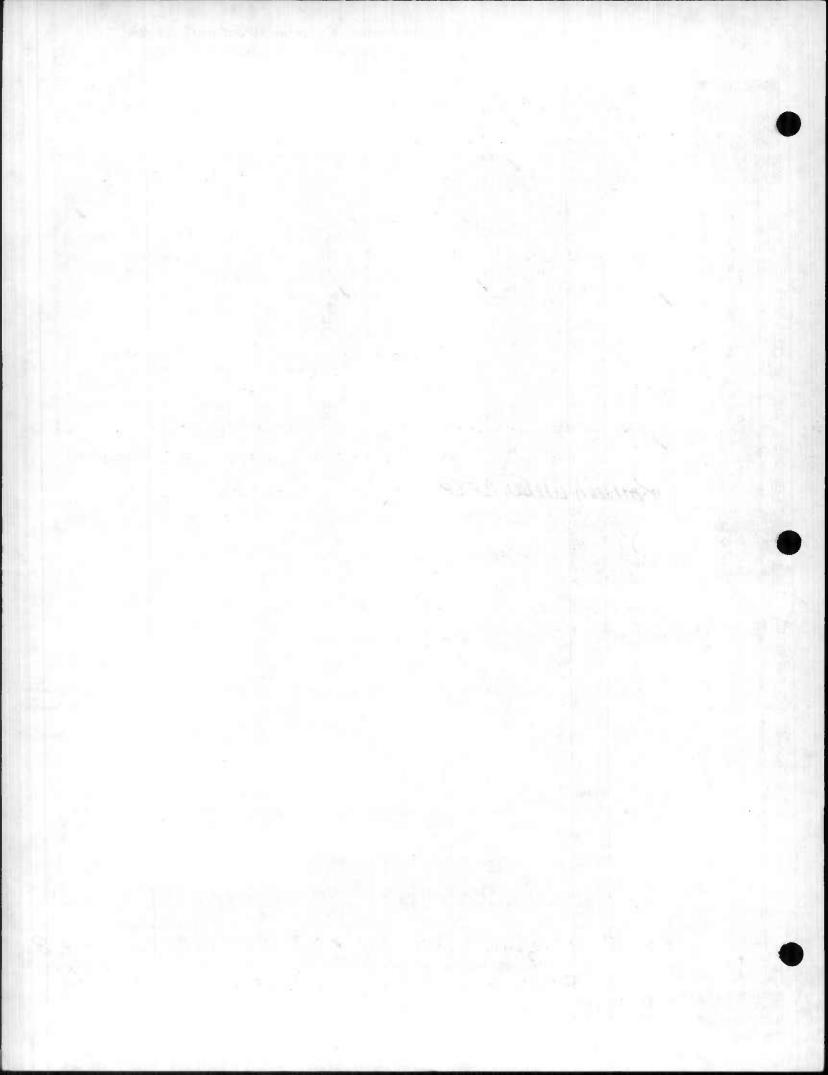
32. Registrer's Signature

Dete of Injury (Month, Day Year)

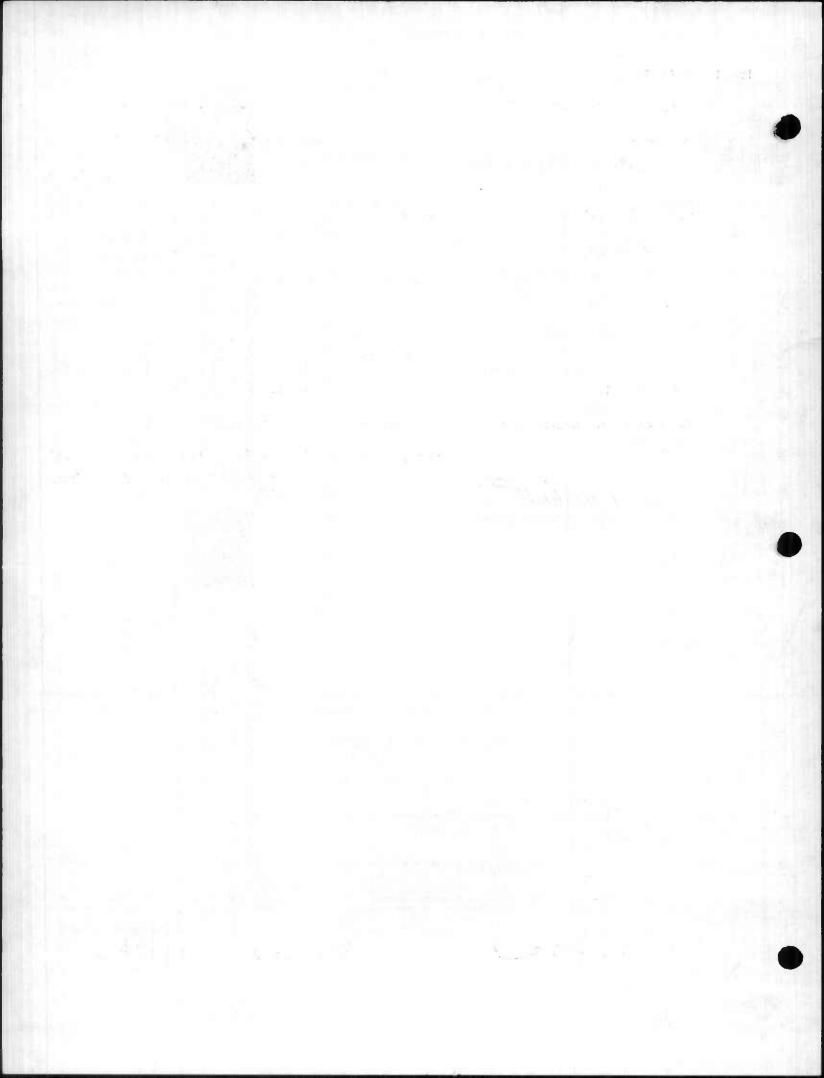


State of Maryland / Department of Health and Mental Hygiene

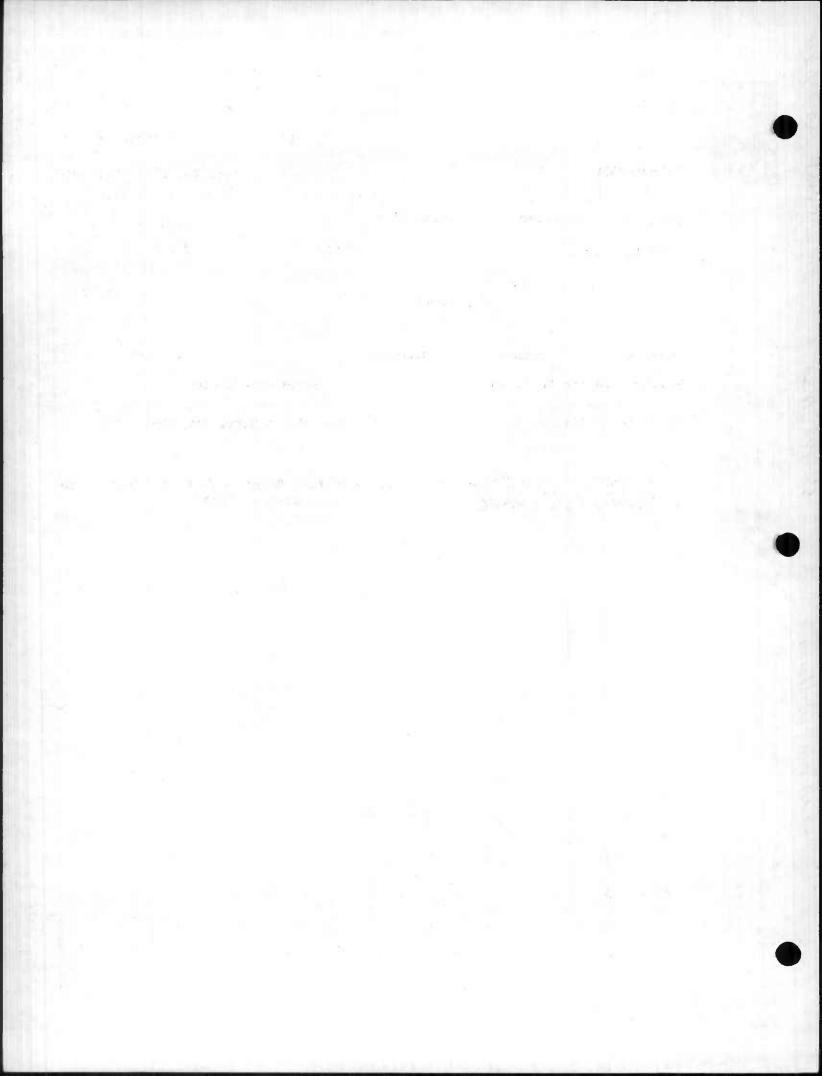
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Nedical	ıl -				\ A /			DAN	26.1	9981	PM			
aminei	r	4e. Facility Name (If not institution, Church Hospi			nit		4b. City, Town, o. Baltim		th 4c. County	y of Deeth				
eral ctor		5. Sociel Security Number 219-28-6882 Usual Residence of Decedent	6. Sex 7. A	Age (In yrs. k	Mont	nder 1 Year ths Days		(Month, E	irth ley, Yeer) 5 / 1 9 1 5	9. Birthplece Country) Polance				
14		10a. State 10b. County		10c. City	, Town or Location					10d. Ir	nside City Li			
the d	010	MD			Baltimo	re				1	Yes 2			
niner must be notified		10e. Straet end Numbar				Zip Code			10g. Citizan of	Whet Country?				
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idmi	2	Elementery/Secondery (0-12)	College (1-4or	r 5+)			during most of we	9						
ant,		17. Father's Name (First, Middle, Li	ast)		Homemal	ker	18. Mother's Na	ama (First, Middle	DOME e, Meiden Sumer	estic				
To Be	0	Wojcieck		Po	lak		Victo	-11		Burdy	71			
emne '		19e. Informant's Name/Relationshi	p (Type, Print)	T all 61	19b. Meiling Addr	ress (Street	n, Stete, Zip Code)							
ner tr		Andrew Stahm 20e. Method of Disposition 1 Buriel 2 Cremation	er/Careta	ker	739 S.	Curl	y Stre	et Bal	timore	Md. 21	224			
50	1			20b. Ple	metery, cremetory	or other pla	ce)	Dete	20c. Location	- City or Town, S	State			
any injury or	-	4 Donetion 5 Other (Spe		но	ly Rosa			1/30	Balti	imore M	1D			
once		21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility David J. Weber Funeral Home 401 S. Chester Street Balto. Md. 2 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrast, Intervel Interve												
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	ysicia	n	1. Decedent's Neme (First, Middle, Last) Harry Sanford Runyan, Sr.			2. Date of De Month January	Dey Yeer	3. Time of Deeth 3:05 AM			
	ledica amine	al er	4e. Fecility Neme (If not institution, give street end number) 66 Dunkirk Rd.		4b. City, Town, or Lo	Location of Death 4c. County of Death					
Fune Direc			Social Sacurity Number 6. Sex 7. Aga (In yrs. lest birthday)	Under 1 Year onths Days			of Birth th, Dev. Yaar) 9. Birthplece (State or Fore				
Maryland -f show	Ded of		Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location Maryland Baltimore Baltimore					10d. Inside City Limits 1 ☐ Yes 2 No			
h with the	at be not	2	10e. Street end Number 66 Dunkirk Rd.	Of. Zip Code 21212			10g. Citizen of What C United Sa	•			
15-0020 n 72 hours efter death with the Manyland "natural", or frems 23s or 28s-f show	Examiner m	2	1 Nevar Married 2 Marriad 1 1 N Yas 2 No	Decedent of His, specify Cub	Hispenic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - Arr Bleck, Wh Specify: W				
Am C		Completed	15. Decedent's Education (Specify only highest grede completed) Elamentary/Secondary (0-12) College (1-4or 5+) 4 16e. Decedent' (Give kind life. DO) 17e. DO) 18e. Decedent's Education 16e. Decedent		petion during most of work d)	16b. Kind of Busines					
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Marylar 12 should be h end Mentel is marked	aumet.		19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing A	ddrass (Street			er, City or Town, State,	, Zip Code)			
Te, N 1 and 2 Heeith	other tr	-	Katherine Rubin/daughter Nurse 66 Dunk 20e. Method of Disposition 1 A Buriel 2 Commetter, 2 Democration 3 Remove from State commetery, cremetor,			ore, MD	21212 20c. Location - City of	or Town, Stata			
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5 00	Tuneral director	2	27. Manner Deeth 1 ☑Netural 5 ☐ Pending (Month, Day Year) 28b. Time of Injury	28c. inju	ner: 4 Nursing Ho	oth (Chack only one) oma 5 Rasidance 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)					
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To the He within 24 To the Fu	Compile		29b. Signature en Transcourant	29c. Licens	se number		29d. Dete signed (Mor	nth, Dey, Year)			
, ,			1 Pape	D	26000	2	1 20	98			
0	1	L	30. Name and address of person who completed cause of daeth (Item 23a) (Type, Print John H. Eppler, M.D. 120 Sister Pierre		Towson, M	D 2120	4				
Reg	State		31. Data filed (Month, Dey, Year) JAN 2,9 1998 Julia Jandson-Randson								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 10 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** Month William Sullivan 1833 98 01 26 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** Berlin Worchester Atlantiz General Hospita If Undar 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 9. Birthpleca (Stata or Foraign Country) Maryland 5. Social Sacurity Number 8. Date of Birth (Month, Day, Year) **Funeral** 8558 1 XM 2 F Days Hours 219-05-8558 Yrs. Director 13, 1918 Usual Rasidence of Decedant the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits "netural", or Items 23a or 28a-f ahow - 05° 1 ☐ Yes XX No Director Maryland Worchester Ocean City 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? U.S.A. 219 21842 504 Lark Lane Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ②Yas 2 □ No If Yas, Giva Yaar or Datas: 1941-45 11. Maritai Status Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Nevar Marriad 2 Married White 1 ☐ Yas 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) unknown unknown unknown unknown Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Pages 1 and 2 should be 1 nent of Health end Mentel I William Stevens Sullivan Marie Anna Eurich 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) nt of Health e If Item 27 is or other tra Patricia Sullivan/wife 504 Lark Lane, Ocean City, Maryland 21842 26/98 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata important: If any Injury o 4 ☑ Donation 5 ☐ Othar (Spacify) 21. Signature of Runal and Street Wade // Director ²² Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, whick, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting In deeth) Cardona **Examiner** Dua to (or as a consequence ot): artery Caronary Sequantially list conditions, if any, laeding to immadiata causa. Enter Underlying Ceusa (Disaasa or injury that initiated avants rasulting in daath) Last Due to (or as a consaguanca of) Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco usa contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Monknown Completed 24a. Was an autopsy performed? 24b. Wara autopsy tindings availabla prior to complation of causa ot deeth? certificate 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No Certification: To this 28a. Data of Injury (Month, Day Year) 27. Mennar of Daath 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Panding invastigation 1 Naturel s after death. 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datamined 3 ☐ Suicide 28e. Placa of Injury - At homa, farm, straat, tactory, office building, etc. (Spacify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 24 hours a Hospital 12 Certifying Physician: To the best of my knowladga, daath occurred at tha tima, date and place, and dua to tha causa(s) and mannar as stated.
2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. edical within 24 hour To the Fune completely file 29a. Certifiar (Check only one) 29b. Signatura and titla of cartifiar 29c. Licansa number D48130 30. Name and activess of person who complated causa of death (Itam 23a) (Type, Print) Atlantiz General Hospital 9733 Healthoung Dr. Berlin, MD b-reenwood, MP Thomas Jeffrey 31. Data tiled (Month, Day, Year) 32, Bagistrar's Signatura State who Daydon Randall JAN 29 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene

If Under 1 Year

Deys

Months

Certificate of Death

	1. [
Physician	
/Medical	_
Evaminer	4e

JAMES SUTTLE JR.

Decedent's Name (First, Middle, Last) James Suttle, Jr. Facility Name (If not institution, give street and number) 2417 ASHTON AVENUE

10b. County

1₽M 2□ F

5. Social Security Number

10e. State

232-56-5280

Usual Residence of Decedent

JAN. 4b. City, Town, or Location of Deeth

BALTIMORE

Min

If Under 24 Hrs.

Hours

Reg. No."

8. Date of Birth (Month, Day, Year) 937

24, 1998

4c. County of Deeth

Baltimore City

Bleck, White, etc.

2. Dete of Deeth

3. Time of Deeth 0825 AM

9. Birthpiece (State or Foreign

10d. inside City Limits

Approximete intervel Between Onset end Deeth

24b. Were autopsy findings eveilable prior to

completion of cause of deeth?

1 TYes 2 No

JAN. 24, 1998

1⊠ Yes 2 No

unknown

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other treumatic event, in Medical Emister must be mattered. Baltimore, Maryland 21215-0020

> Physician /Medical Examiner

attending physician end for use es the buriel-transit that the death certificate be executed signed t The law requires pege 2 certificate hes Hospital or Attending Physician: this funeral After deeth. ector: A 0 Dire 24 hours

P.O. Box 68760,

Division of Vital Records,

Maryland Baltimore City Baltimore Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2417 Ashton Street U.S.A. 21223 Funeral 12. Wes Decedent Ever in U.S.
Armed Forces? unknown
1 □ Yes. 2 □ No
If Yes, Give
Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indien. 11. Maritai Status unknown 1 □ Never Married 2 □ Married 1 Yes 2₺ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) unknown unknown unknown unknown 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be unknown unknown 19a. informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown unknown 20b. Piece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion _5 NOther (Specify) in state ²²State Anatomy Board, 655 W. Baltimore Street 21. Signeture of Fundral Pervice Licenseed Director Baltimore, Maryland 21201 23a. ert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart feiture. List only one cause on each line. immediate Cause (Final diseese or condition resulting in deeth) **EMPHYSEMA** Due to (or es e consequenca of): Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury Due to (or es e consequença of): that Initieted events resulting in death) Lest Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown **ASTHMA** by 24a. Wes en eutopsy Completed INSPECTION 1 ☐ Yes 2 🖺 No 25. Wes case referred to medicel exeminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🛱 Residence 6 ☐ Other (Specify) XYes 2□ No 20 28d. Describe how injury occurred 27 Menner of Deeth 28a. Dete of injury (Month, Day Year) 28b. Time of 28c. injury et Work? Certification: Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. edical (Check only one) Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year)

7. Age (In vrs. last birthday)

Yrs.

10c. City, Town or Location

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State Registrar

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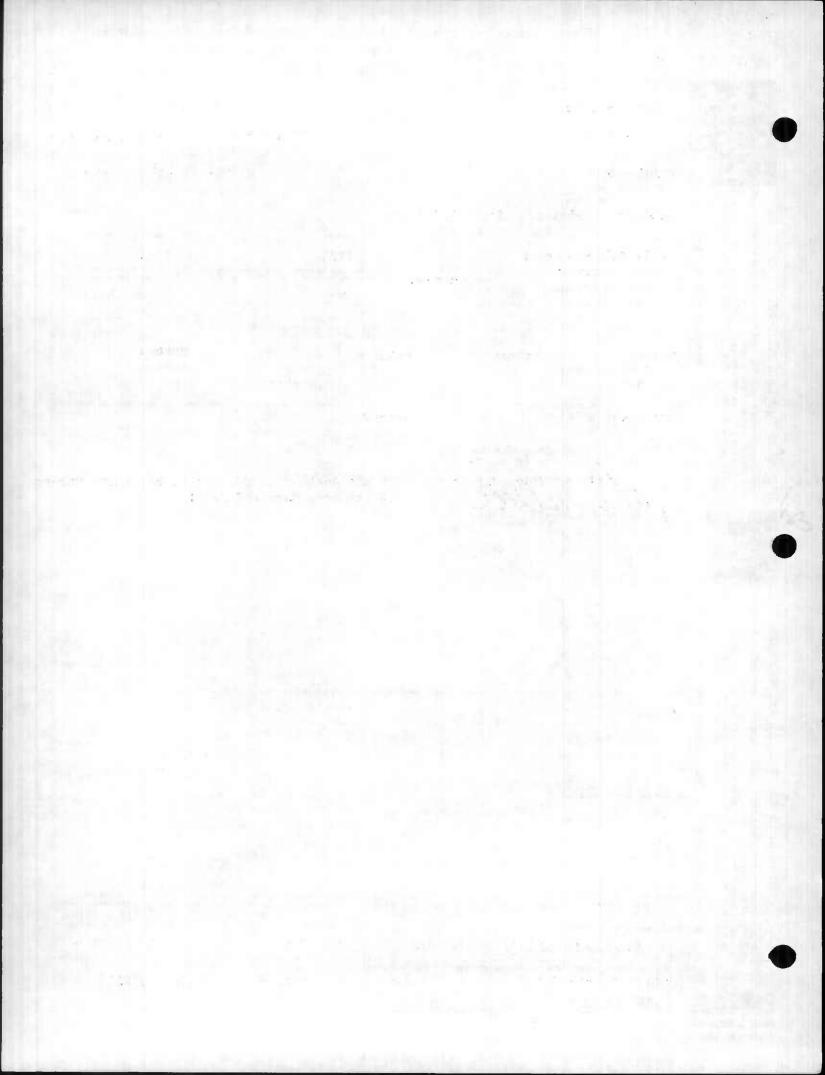
old.

30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print)

Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201 Julia Lawidson - Handale

ght MD

O.C.M.E



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month Yeer BARBARA SWIFT JAN. 27 1998 5:38 P.M. JANE 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth BALTIMORE CITY If Under 24 Hrs. Hours Min. 8. Dete of B GOOD SAMARITAN HOSPITAL If Under 1 Year 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 6 Sex Months 1 M 2 TF Deys MARYLAND 219-10-0663 11/21/25 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 ☐ No N/A BALTIMORE CITY 10e. Street end Number 10f. Zip Code 10g Citizen of What Country? 6718 GLENKIRK ROAD 21239 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-tf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus 1 Never Married 27 Married 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced WHITE 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12th GRADE SALES PERSON STEWARTS 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) ARTHUR MAYNOR ELSIE NEIGHBOR 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) FRANCIS L. SWIFT HUSBAND 6718 GLENKIRK ROAD BALTIMORE, MD 21239 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 1/30/98 COCKEYSVILLE, MD DULANEY VALLEY MEM. GAR. 21. Signeture of Funeral Service Licensee JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD or heart failure. List only one cause on each line. 21.286 Approximete thterval Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Due to (or es e consequença of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 2 No 25. Wes case referred to medical exeminer? 28. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

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Certification:

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Division of Vital Records, P.O. Box 68760,

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23s or 28s-f show placy or other treumatic event, tra Medical Examinar must be notified and once.

Examine Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events resulting in deeth) Lest Physician/Medical 2 2 8

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part 1.

ypertension

1 Yes 2 No 27. Menner of Deeth 1 Neturel 2 Accident

3 Suicide

28e. Dete of Injury (Month, Dey Year) 5 Pending investigation 6 Could not be determined

28b. Time of 28c. Injury at Work? 1 Yes 2 No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

BALTO. MD

4 Homicide 29a. Certifier 1 Certifying Phyeiclen: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner stated. (Check only one)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29b. Signature and title of certifier

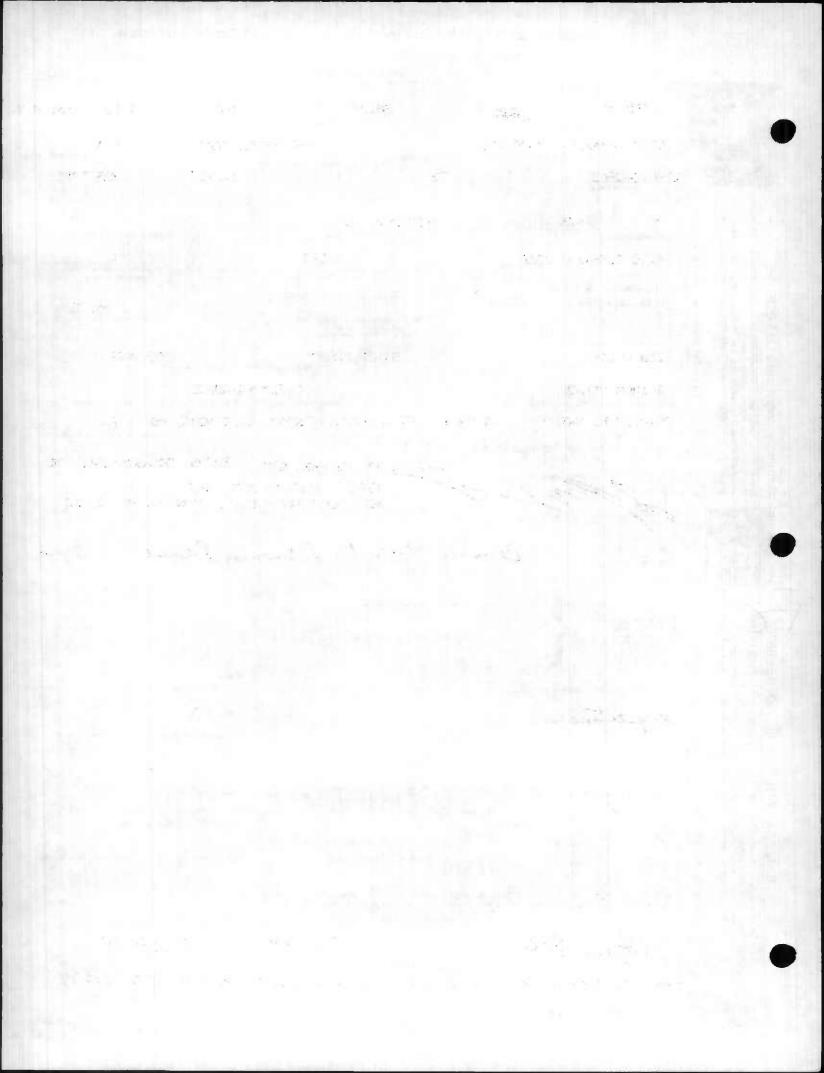
29c. License number D28987 29d. Date signed (Month, Day, Year) 1-28-98

30. Name and address of person who completed cause of deeth (item 23e) (Type, Print)

MID. 5601 LOCH RAVEN BLUD SPERLING

31. Dete filed (Month, Dey, Year) 29 1998 32. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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HALL A CLARK The second V 1. 1951 15 and the same of the same of the

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Elizabeth M. Stover 23,1998 4c. County of Deeth JANUARY 02:50 AM /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth **Examiner** BALTIMORE TOWSON BALTIMORE MEDICAL CENTER GREATER If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (Stete or Foreign Country) **Funeral** Deys 1□ M 21 F Yrs. Director 220-01-3777 1916 81 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3513 Northern Parkway, Apt B2 21206 U. S. A. 12. Wes Decedent Ever in U,S. Armed Forces?

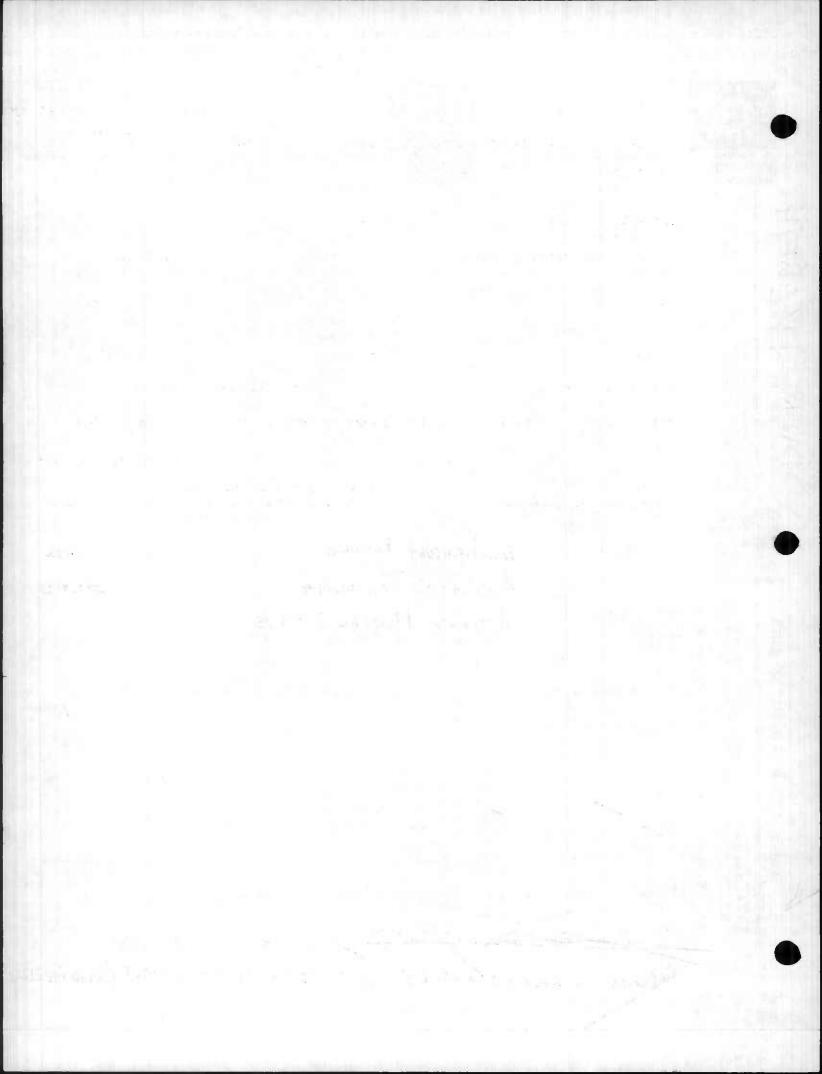
1 ☐ Yes 2 1 No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: à 3 X Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Depertment of Heelth and Mental Hygiene. mportant: If item 27 is marked other than Elementery/Secondery (0-12) College (1-4or 5+) 12th Grade Secretary Hospital 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Joseph L. Morrow Mary Elizabeth Chambers 19e. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Anthony Stover (Son) 1504 Amesbury Court, Bel Air, Maryland 21014 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Buriei 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Oak Lawn Cemetery 1/26/98 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Schimunek Funeral Home Inc. read 3331 Brehms Lane, Baltimore, Maryland 21213 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, and, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** FAILURE /Medical Immediete Cause (Finel RESPIRATORY 3 MAYS diseese or condition resulting In death) **Examiner** Examiner PREUNONA 3 DAYS SPIRATION The law requires that the death certificate be executed physician end st the buriel-trens Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Box 68760. ALTERSID Physician/Medical Due to (or es e consequence of) for use es signed by the e P.O. Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Dld tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, by 24e. Wes en eutopsy performed? Completed 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? pege 2 s certificate 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpetient 3 DOA Certification: To this funeral 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending Investigation 1 Naturel e deeth. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) or A effe 4 Homicide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature od title of certifie 29d. Date signed (Month, Dey, Year) 1/24/98.

30. Name and address of person who completed cause of about (Item 23e) (Type, Print) Swite 2853 Name Street

32 Regional s Signature

DHMH 16 Rev 6/95

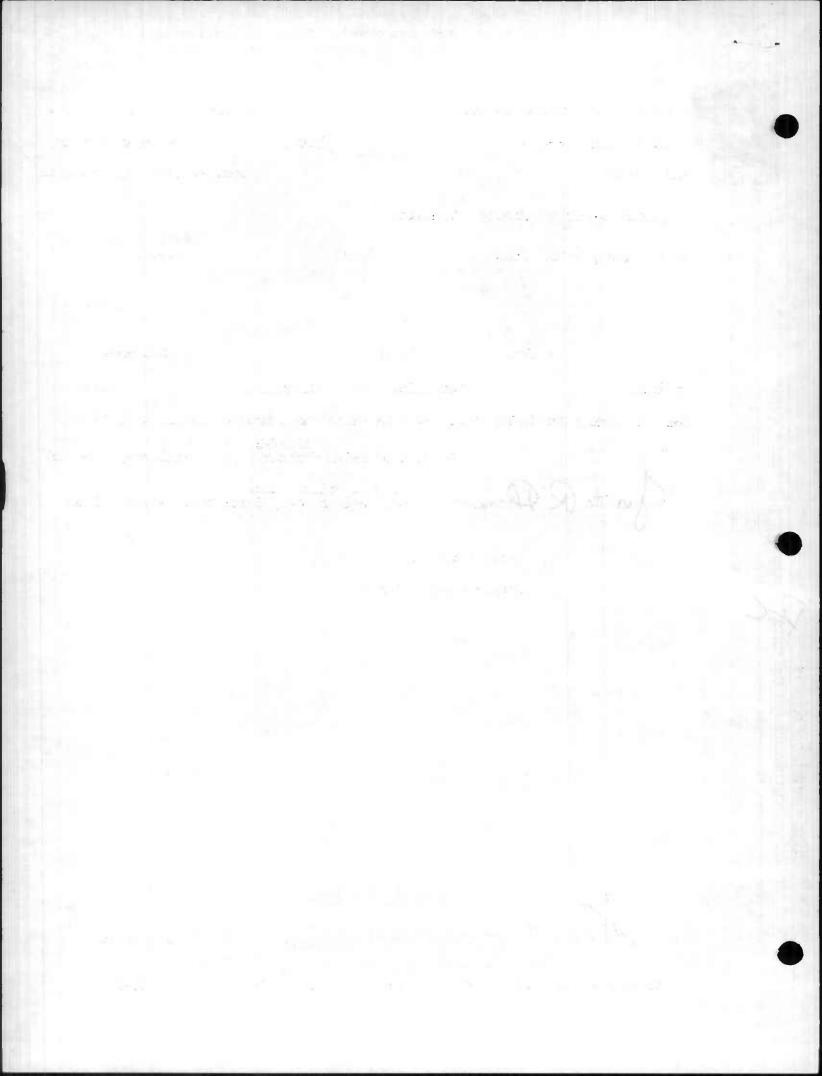
State Registrar



State of Maryland / Department of Health and Mental Hygiene 0222

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CATHERINE SCHMITT



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 12.00 Am Alma N. Trumpler January 1998 28 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Aroundal Hospital Glen Burnie Anne Arrandel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funerai** 1□ M 2⊠ F Months 214-12-2144 82 Director March 16, 1915 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner main be inclined at 1 Tyes 2K No Director Maryland Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 707 Juniper Rd. 21090 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) permit. Pages 1 and 2 should be filed within Deportment of Health end Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Charles Kriewald Martha Deichgraber 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Albert L. Trumpler/ Husband 707 Juniper Rd., Linthicum, Maryland 21090 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State January 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 30, 1998 Glen Burnie, Maryland ure of Euneral Service Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 0 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** of the Brain Stem Immediate Cause (Final disease or condition resulting in death) /Medical Stroke Three days **Examiner** Due to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of) Box 68760 Physician/Medical phy: Due to (or as a consequence of) 98 Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobecco uee contribute to the cause of deeth? 1 Tes 2 No 3 Probably 4 Unknown Hyponatremia þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Was an autopsy performed? Completed 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: efter death. Director: After this certifica 25. Was cese referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 24 hours e 1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es steted.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I within 2 To the I complet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 1 Sherif Elassal, M.D. Be 5333644 January, 28, 1998 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Worth Aroundal Hospital 301 Hospital Drive Glen Burmie MD61 Sherib Elassed July Begistrar's Signature

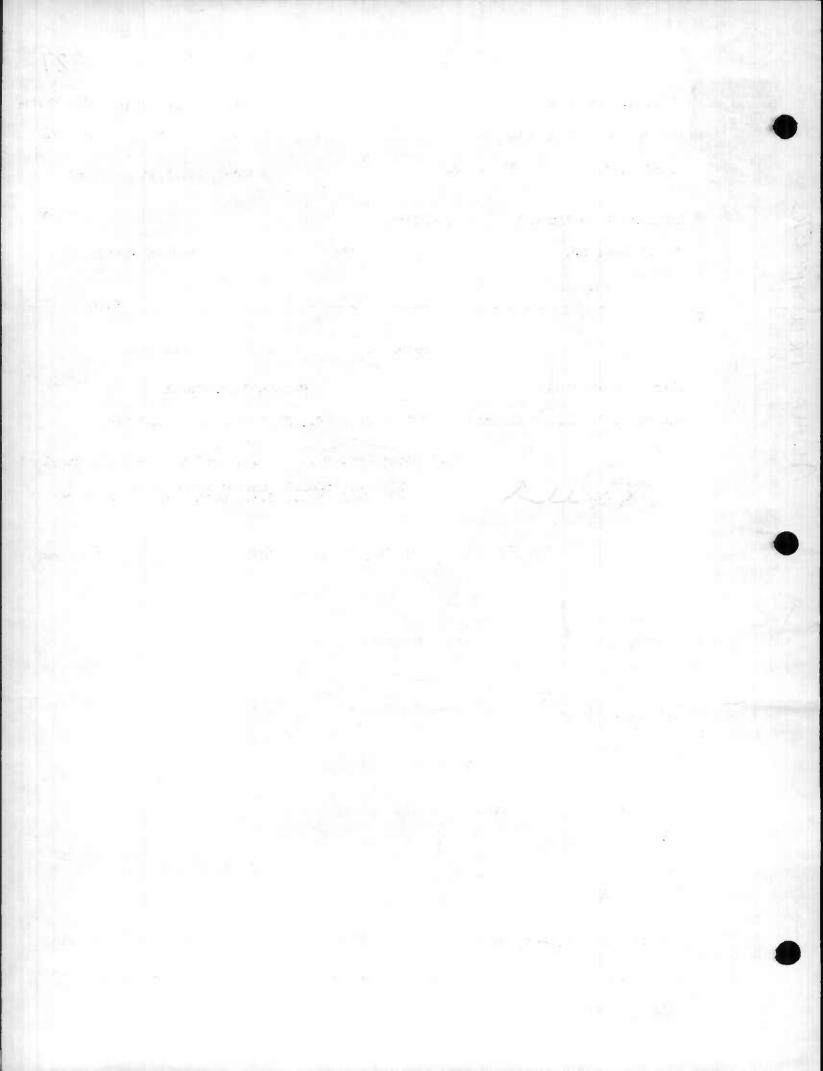
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Registrar

31. Date filed (Month, Day, Year) JAN 29 1998

TRUMPLER

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician /Medical **Examiner**

Funeral Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at "natural", or items al Hygiene. Pages 1 and 2 should be fill ment of Health and Mental H lant: If item 27 is marked out other permit. Page Department of Important: If any injury or once.

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Physician /Medical **Examiner**

Physician/Medical Examin 68760 physician s the buria attending ; signed by t d be detect by Completed page 2 Be Medical Certification: To this Attending death. offer death offer death Director: / Hospital of 24 hours of Funeral Dietely filled is

To the To the comple State Registrar

1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Irene Marie Timen january 23, 1998 7:00PM 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Ridgeway Nursing Home Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 09/07/1911 Birthplece (State or Foreign Country) Days 1□M 2\ F Months Hours 86 Yrs. 335-05-7591 Illinois Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits Director 1 Yes 2 No Maryland Baltimore Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21228 4 Rumford Drive Unit 204 USA Funera 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Merried 2 Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Cashier Retail Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Wasielewski Catherine Lipecki 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21228 4 Rumford Drive Unit 204 Catonsville, Maryland Karen Modler / Daughter 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removel from State All Saints Cemetery 1/30/98 Des Plains, Illinois 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Fecility David J. Weber Funeral Home 5311 Edmondson Ave. Baltimore, Maryland 21229 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth Fleetryte Inbalance es e consequence of. Dysphy ier/maln trition Immediate Ceuse (Final disease or condition resulting in deeth) low days Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Lest years Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown STED DUNGES 24b. Were eutopsy findings availeble prior to completion of cause of deeth? Pernicious America 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending Investigation 1 Natural 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide

10 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier

29b. Signature and title of certifies Kajor MD 29c. License number

29d. Date signed (Month, Dey, Year)

GEETHA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GETHA RATA 4367 HOLLING FENNY Rd, BULLINGUE, MD 21227

31. Dete filed (Month, Day, Year)

32. Registrar's Signature Davidson Thandall

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death **Physician** JANUARY 22, 1998 SHIRLEY TEUFEL 11:26 PM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number)
Saint Joseph Medical Center 4c. County of Deeth Examiner Baltimore Towson If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 7/30/30 7. Age (In yrs. lest birthdey) If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number Deys Hours 1 M 2 F 67 Yrs. 218-28-2576 MARYLAND Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director BALTIMORE PARKVILLE 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 1728 WESTON AVENUE 21234 Funeral 12. Wes Decadent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) RELIGIOUS Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY ORGANIZATION 12th GRADE 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be CHARLES COLLIER LENA PANUSKA 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) HUSBAND RAYMOND TEUFEL 1728 WESTON AVENUE BALTIMORE, MD 21234 20b. Place of Disposition (Name of cametery, cremetory or other placa) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Burial 2 Cremetion 3 Removel from State 5 Other (Specify) 4 Donetion DULANEY VALLEY MEM. GAR. 1/27/98 | COCKEYSVILLE, MD 21. Signature of Funeral Servica Licensee 22. Name and Address of Fecility JOHNSON FUNERAL HOME, P.A. 23a Part V. Enter the disease, or complications that daused the deeth. Do not enter hock, or heer feilure. List only one ceuse on each line. TOWSON, MD_ 8521 LOCH RAVICIDET VID TOWSO enter the mode of dying, such as cardiac or respiretory errest, 21286 Approximate Interval Between Onset end Deeth POSTERIOR WALL MYOCARDIAL INFARCTION 3 DAYS Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequenca of): ARTERIOSCLEROTIC CORONARY ARTERY DISEASE 30 YEARS Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 | Yas 2 | No 3 Probably 4 Unknown CORONARY ARTERY BYPASS SURGERY Aq 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en eutopsy Completed 1 TyrYes 2 □ No Y Yes 2 No Be 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) To Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, In my opinion, death occurred at the time, date end plece, end due to the cause(s) and menner stated. 29b. Signeture and tillig of certifig 29d. Date signed (Month. Dev. Year) 29c. License number 44080 30. Name engleddress of person who completed cause of deeth (Item 23e) (Type, Print)
FRANCIS J VARGA, M.D., 762Ø YORK ROAD TOWSON, MARYLAND 212Ø4

State Registrar

Funeral

Director

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than "natural", or items 23s or the Medical Examiner must be r

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72 hours after

permit. Pages 1 and 2 should be filed within 72.1 Department of Health and Merical Hygiene. Important: If them 27 is marked other resemble layer.

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Division of Vital Records.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth Month **Physician** 7010 PM KHAMSAD THAMMAVONG 26 1998 JANUMY /Medical 4a. Facility Name (If not Institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Church Home Hospital Baltimore N/a 7. Age (In yrs. last birthday) | If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Months, Day, Year) | Months | Deys | Hours | Min. | March 3, 1902 6. Sax 1 ☑ M 2 ☐ F 5. Social Security Number Birthpleca (Stata or Foreign Country) **Funeral Director** 341-68-4481 Laos Usuei Residence of Decedent with the Merylend 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show The Medical Examiner must be notified at 1 Yes 2 No Maryland Directo N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours effer deeth v
Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a and injury or other traumatic event, the Medical Exercises 200. 613 N. Potomac Street 21205 Laos Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 Ø No If Yes, Give Yaar or Datas: Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bieck, White, atc. 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à 3 ₩idowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Unknown Farmer Farming 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Meiden Surname) Unknown Unknown 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ounkham Thammavong (Grandson) 613 N. Potomac Street, Baltimore, Maryland 21205 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Crametion 3 Ramoval from Stata 4 Donetion 5 Othar (Specify) Meadowridge Mem. Park 1/31/98 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Schumuner Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Pert1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heer tailure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) . SEMSIS 1 Dry Examiner Due to (or es e consequenca of): Examiner PNEUMUMA that the death certificate be executed ettending physician end for use es the buriel-transit Sequentially list conditions, if eny, laeding to Immadiate cause. Enter Underlying Ceuse (Disease or Injury that initiated evants resulting in death) Last Due to (or es e consequance of): Box 68760. Physician/Medical Dua to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. Otylsion of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 Yes 20 No 3 Probably 4 Unknown RENN FAUNC à 24b. Were eutopsy findings aveilable prior to completion of causa of deeth? AMEMIUSCUMUTIC COMDINUASCINION DISPASE 24e. Wes en eutopsy performed? Completed hes 1 ☐ Yes 2 ☐ No dospital of Attending Physician: funeral director, Be 25. Was case referred to medical 28. Place of Deeth (Check only one) axaminer? Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 After this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation Neturel 1 ☐ Yes 2 ☐ No urs efter death 2 Accident 3 Sulcide 8 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and dua to the cause(s) end menner stated. 29e. Certifier Medicai To the Lost within 24 ho To the Furn completely i (Check only one) 29c. Licansa number 29d. Date signed (Month, Dey, Year) 29b. Signeture end titia of certified

State Registrar PENEWNE
31. Dete filed (Month, Dey, Year)

JAN 29 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

P. SUTT MD IVU N. BWDWAY BANNUS, MD 21231

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Jammy 20, 1994

State of Maryland / Department of Health and Mental Hygiene 8

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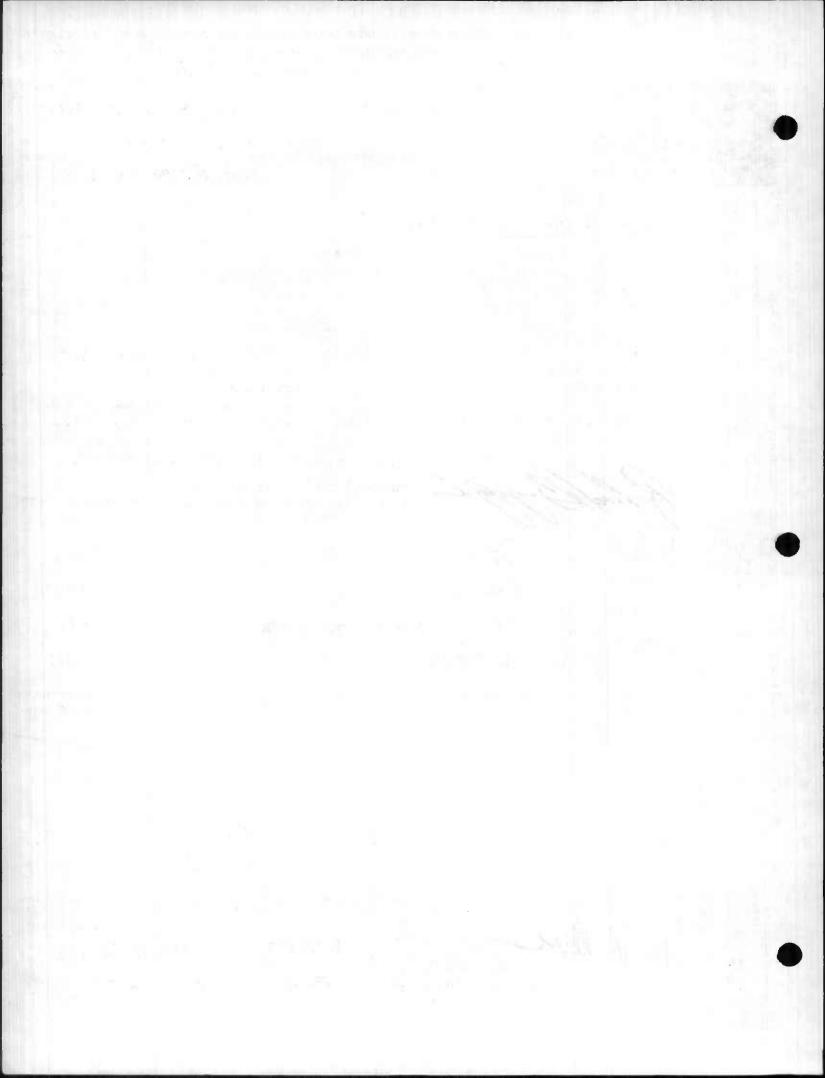
State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Year Jennie Vendetti January 26,1998 4:40pm /Medical 4e. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Mariner Health of Forest Hill Forest Hill Harford If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1 M 2 T 216 07 4088 Yrs. Director 83 26,1914 Maryland Usuel Residence of Deceden deeth with the Marylend 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1□ Yes 2□ No Director Maryland Harford Abingdon 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3847-D Memory Lane 21009 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritat Status permit. Peges 1 and 2 should be filed within 72 hours effer of Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exertimes once. 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: by Specify: 312 Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Seamstress Clothing Mfg. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) John Kovitzka Mary Cherish 19a. Informent's Name/Retetionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Angelina DiPinto (daughter) 3409 Agusta Road Manchester, Md. 21102 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriat 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cemetery1/29/1998 Baltimore, Md. 22. Name end Address of Fecility Bruzdzinski Funeral Home PA 1407 Old Eastern Ave Essex, Maryland 21221 Capon that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, necessition each line. Approximete Intervet Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel Weck disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner 2 months 6 ANGRUENE Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): VASCUCIAR Yeurs ERIPHERAZ P.O. Box 68760 Physician/Medicai Due to (or es e consequence of) IMBETES Pertes signed by the e Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown þ 24b. Were eutopsy findings evelleble prior to Completed 24e. Wes en eutopsy performed? peen completion of ceuse of deeth? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No certificete Division of Vital 25. Was cese referred to medical Be 26. Ptece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No funeral c 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Neturel 2 Accident 5 Pending Mospital or Attending 24 hours effer death. Funerei Director; Aft 1 Yes 2 No investigation 6 Could not be determined To the Hospital or Atter within 24 hours efter der To the Funeral Director completely filled in by th 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the besis of exeminetion end/or Investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted. edicai 29a. Certifier 29b. Signeture end title of could 29d. Date signed (Month, Dey, Yeer) 29c. License number 22843 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) R. PHILLIPS 21050 7005 RUCK JPRING RU FORUST HILL

State Registrar 31. Date filed (Month, Day, Year)

32. Registrer's Signature

the Davidson



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Maria Ward 93584 January /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** Baltimore Ba1 Hospital 9 KA timore If Undar 1 Yaar 5. Social Security Number 6 Sax 7. Aga (In yrs. last birthday) If Undar 24 Hrs. Birthplaca (Stata or Foreign Country) **Funeral** Months Days Hours 1 M 2 W 577.48.3633 Director Usual Rasidenca of Decadant with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Insida City Limits 28a-f show r than "natural", or Items 23a or 28a-f show the Wed call Examiner must be notified at Md NA Baltimore 1 THE 2 NO Director 10e. Sfreet and Number 10f. Zip Coda 10g. Citizen of What Country? 2121 2404 austerstown AZU Funeral filed within 72 hours after death 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No 11. Marifal Status Was Dacedanf of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, White, atc. 1 Navar Married 2 Married 21215-0020 1 Yas 2 YNo Completed by Specify: lac 3 Widowad 4 Divorced 16a. Dacedant's Usual Occupation
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LOUNDER WORLD 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highast grada complated) al Hygiena. Elementery/Secondary (0-12) ayndeomo marade Baltimore, Maryland 17, Fathar's Nama (First, Middle, Last) permit. Pagas 1 and 2 should be file Dapartmant of Health and Mental Hy Important: If Item 27 is marked other you or other traumatic event 18. Mothar's Nama (First, Middle, Maldan Sumama) Be San H JONES 0 ESSIE 19a. Informant's Name/Raiatlonship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Routa Number, City or Town, Steta, Zip Coda) d liltos Ward 2406 Keisteestows Dalto 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 1-30.98 4 ☐ Donation 5 ☐ Othar (Specify) torost Uet, Jakkison 22. Nama and Addrass of Facility 21. Signatura of Fundral Service Licensee C. March 4300 Wabash 21215 23a. Part1. Entar the disease, or complications that clused the death. Do not anfar the mode of dying, such as cardiac or respiratory arrast shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final SEPSIS disaasa or condition rasulting in death) one month Examiner Dua to (or as a consequance of): Perinephric abscess Sequantially list conditions, if any, laading to Immadiata ceusa. Entar Undarlying Causa (Disaasa or injury that initiatad evants rasulting in daath) Lasf Dua to (or as a consequance of): 68760 Physician/Medical Dua to (or as a consequanca of): certificate guib The law requires that the death. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? Division of Vital Records, P.O. signed by 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24a. Wes en autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? cartificate 2 19 No 1 ☐ Yas 2 ☐ No 8 25. Wes case rafarred to medicel 28. Place of Deeth (Chack only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 10 1 Yas 2 No 1 Impatiant 2 ER/Outpatient 3 DOA After this 28a. Data of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Attending 5 Panding investigation 1 Natural death. 1 ☐ Yas 2 ☐ No 2 Accidant after death Director: 6 Could not be 3 Suicida Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) in by 4 ☐ Homicida 8 To the Hospital within 24 hours a To the Funeral C 1 Cartifying Phyalcian: To the best of my knowladga, death occurred et tha tima, data and plece, end dua to tha causa(s) and menner es statad. Medical 29a. Certifier 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the filme, dete and place, and due to the cause(s) and manner stated. 29b. Signatura and titia of certifiar 29c. Licansa number 29d. Dafa signad (Month, Day, Yaar) AS2402321PG9024 Ulno, January 30. Nama and addrass of person who complated ceusa of death (Itam 23e) (Type, Print) Sinai Hospital, Baltimore, Maryland Patr Green MA 32. Registrar's Styrature Randole

State Registrar

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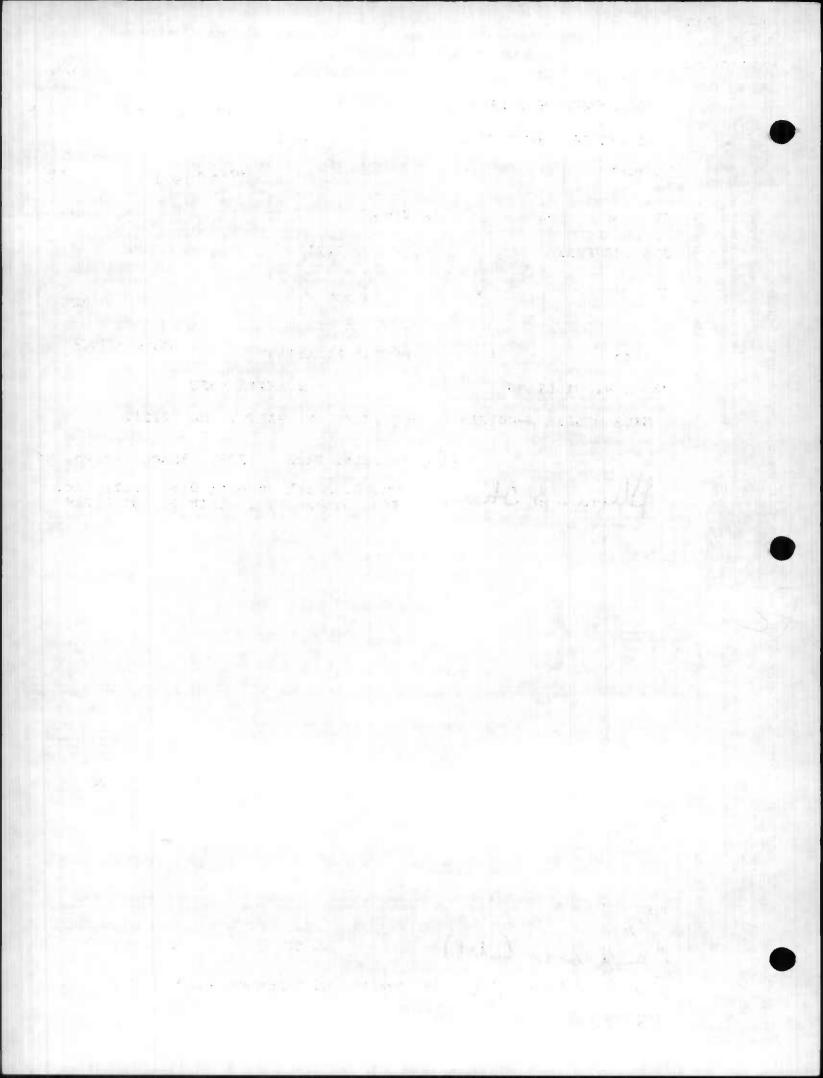


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Baltimore, I	Pages 1 and nent of Health int: If Item 27 iry or other tr		20a. Method of Dispo		Removel from	20b.	Plece of Dispo cemetery, crer ng Men	sition (Na netory or	me of other plac	>e)	1	Date 3098	20c. Location -	City or Town		
	Pemil: Pag Pemil: Pag Physician Infortant: I		23a. Pert1 Enter the shock, or heart Immadiata Causa (F diseese or condition resulting in death)			IARCOTIC	43	300 ar the mo	Waba de of dyir	ash A	ve.	Bal	Home We to., Mo	21:	Inc. 215 oproximete nterval Between onset end Deeth	
Box 68760.	certificate by executed nding physician and use as the burial transit	Physician/Medical Examiner	Sequentially list confi eny, leeding to imm cause. Enter Under Ceuse (Disease or in that initieted events resulting in death) Le	ying njury	b cd.		or as a conseq									
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Division of	pital or Attending ours after death. eral Director: After filled in by the fune	Certification:	1 □ Natural 2 □ Accident 3 □ Suicide 4 □ Homicide	5 Pending investigation 6XXCould not be determined	1/25/ 28e. Place	98	unknown	М	1 🗆	Yes 2		unknown 28f. Location (Street and Number or Rural R. City or Town, State)			Route Number,	
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	To the Hospital within 24 hours To the Funeral completely filled	Med	29b. Signature end ti			ner steted.	Salon Grayor In		c. Licens	e number	occurre	or me une	29d. Data signe		ay, Year)	
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Registrar

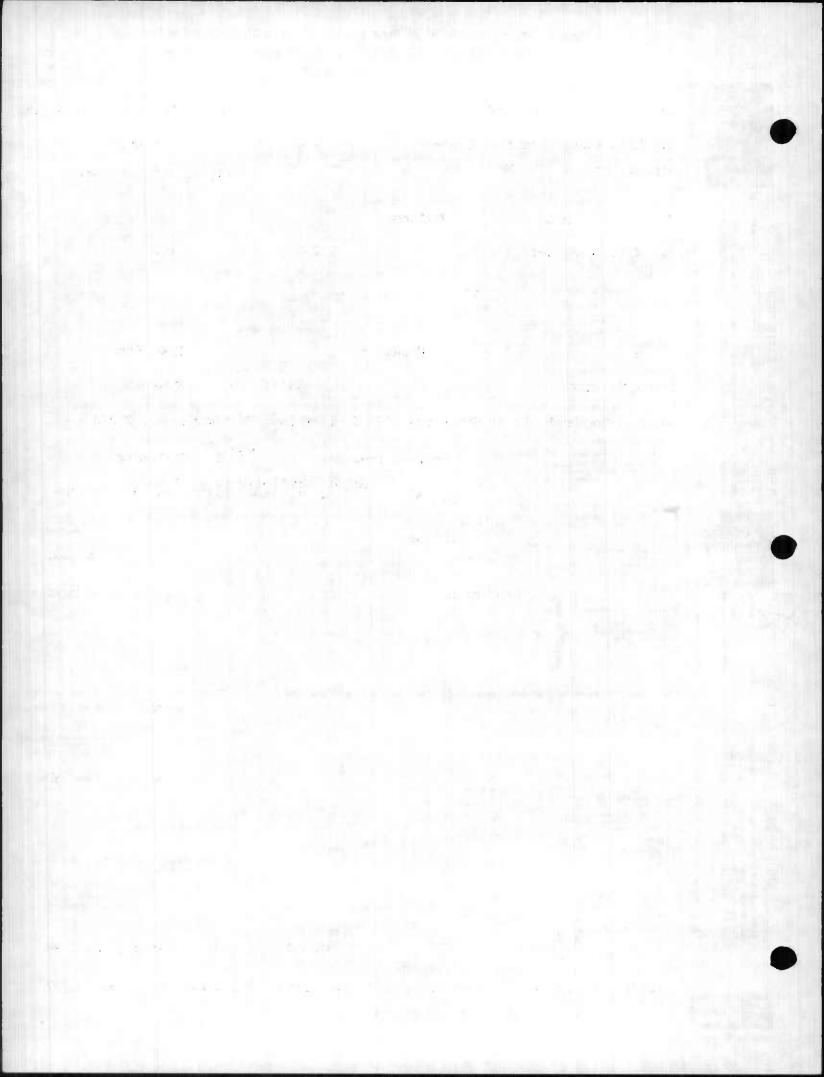
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State of Maryland / Department of Health and Mental Hygiene 8

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		in Squar	-				1 #11-4	4 1/4	Roseda			Balti		
eral ctor	5. Social Secur 218–42		6. Sex 1 □	M 2⊠F	7. Age (In yrs. 95	last birthday) Yrs.	Months	er 1 Year Deys		Min.	8. Date of Bir (Month, Da July 2	th y, Year) 21 1902	9. Birtl Co. Per	nplece (State or Fountry) 1na •
		ce of Decedent			1									
5	10e. State	10b. Count	,			ty, Town or Lo								10d. Inside City Li
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by Funeral Director	3 □Widow	lus Merried 2 Ma ed 4 Divorce	rried	2. Was Dece Armed Fo 1 Tes If Yes, Giv Year or D	2 ∑ No ⁄9				Hispanic Orig ban, Mexican, Specify:	in? (Spe Puerto	ecify Yes or No Rican, etc.)	14. Rac Bla Specify	ck, White	rican Indian, a, etc. white
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-		's Name/Reletion	ship /Tvn	e. Print)		19b. Maili	na Addre	ss (Stree	et and Numbe	r or Rure	I Route Numb	er, City or Town,	State, 2	(ip Code)
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5	20a. Method of		ucii ,	(02000		Place of Dispo					Date	20c. Location		
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any injury or other treumatic event, the medical ance. To Be Completed	21. Signeture	of Funeral Service	e Licanse	L. to	open	25 25	2. Name MC 1.3	Cul.	ess of Facility LY—POLY Fort	ynia Ave	k Funer Balt	cal Home imore, N	id. 2	21230
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ian	shock, or	heart failure. Lis	st only one	e cause on e	ach line.								1	Approximate Interval Betwee Onset end Dea
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ici a	Port II Othor a	Ignificant condit	lone cont	ributing to de	anth hut not ros	culting in the u	inderlylna	COLICO A	iven in Part I		23h Did	tobacco use co	ntribute	to the cause of d
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T:T	27. Manner of I	Deeth			of Injury th, Dey Year)	28b. Time o		28c. Inj	ury et		28d. Describe	how injury occu	rred	
tio	1 Netura		ling stigation	(Mon	iii, Dey Tear)	Injury	М		ork? ☐Yes 2☐f	No				
lica	3 ☐ Suicid	e 6 □ Could	d not be	28e. Plece	of Injury - At h	ome farm st	reet facto	ory, office	9		28f. Location	Street and Num	ber or Ri	ural Route Number
	4 Homic	ide deter	mined	buildi	of Injury - At h ng, etc. (Speci	fy)		.,,			City or To	wn, State)		
1	29a. Certifier (Check onl	1 Certify	ring Phyal	clan: To the	best of my kno	owledge, deet	h occurre	d et the	time, date and	d plece,	end due to the	ceuse(s) end m	anner es	s stated. to the cause(s)
ical Certification:		1	1	end man	ner stated.		100			556411				
edical Certif	one)	And sittle of certifi	ide				2	9c. Licer	nse number			29d. Date signe	ed (Mont	h, Dey, Year)
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edical	1	Sin	xun	_				D.	30470			Janua	Ly 2	.0, 1990
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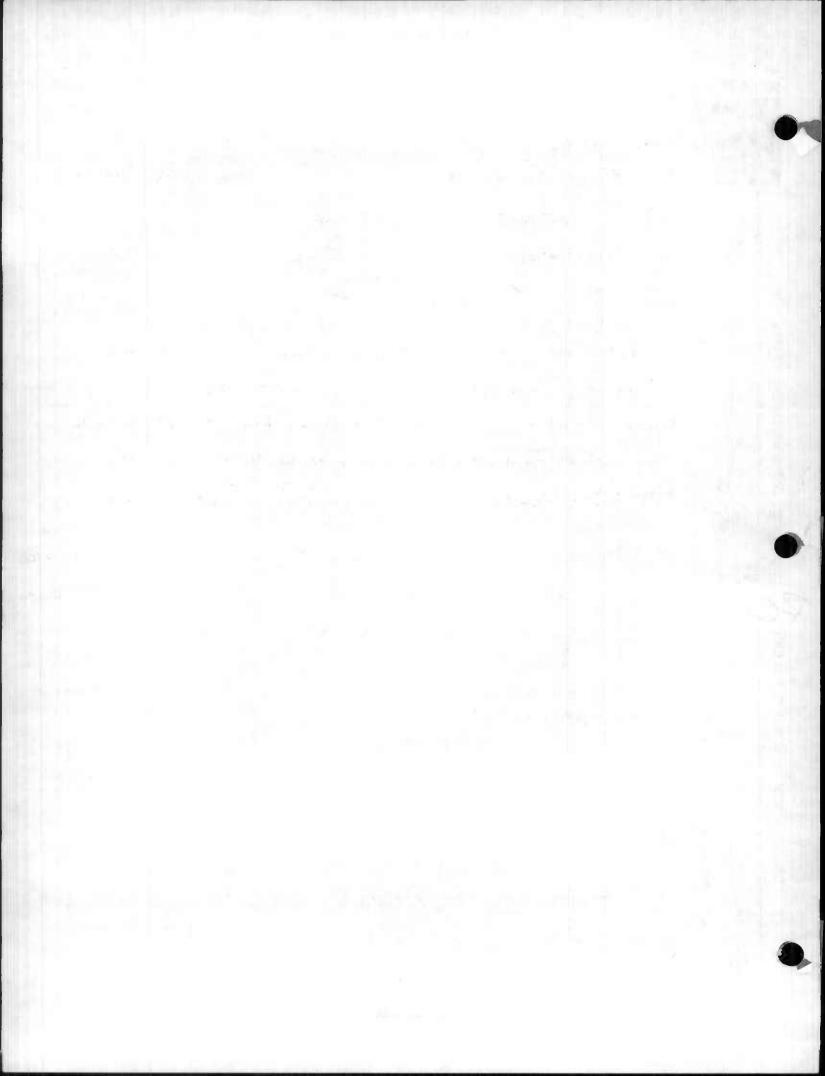
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death Month Dev Veer **Physician** WILSON OHN 6:48 pm JANUARY 15 1998 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTO, MD Alu BAYVIEW HOPKINS JOHNS If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yaar) If Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Months Deys Yrs 218-07-459 MARYLAND Director APRIL 15, 192 Usual Residence of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show MD 1 ☐ Yes 2 ☐ No BALTIMORE Director BALTIMERE 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code U.S.A PARKTOWNE RD 2123 3077 death v Funerai Race - American Indien, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?

1 Ves 2 No
If Yes, Give
Yeer or Dates: permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Exemption 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by Specify: WHITE 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) B.G.E CUSTOMER Service NIA 17. Father's Neme (First, Middle, Last) 18. Mother's Nema (First, Middla, Maidan Sumama) Be SR. John A. Wilson RUTH DEX 2 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Numbar or Rural Route Number, City or Town, Stete, Zip Code) Robert . J. WILSON AVE BALTO MD 21322 WOODLEY 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State
4 Donation 5 Wither (Specify) Entrophent GARDENS OF FRITH CEMETERY 1-29-98 BALTO, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Miller Funeral Home alle Miller Harford KD BALTS. MD. 21234 7527 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Onset end Deeth Physician Immediate Ceuse (Final disease or condition rasulting in daath) /Medical Ventricular Fibrillation/Arrhythmia Examiner Due to (or es e consaquance of): Physician/Medicai Examiner PROBABLE INFARCTED BOWEL Sequentielly list conditions, if eny, laading to immediate cause. Enter Underlying Cause (Diseesa or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) attending physiclen for use es the buriel Box 68760, The law requires thet the death certificate be Due to (or es e consequence of) P.O. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CEREBROVASCULAR ACCIDENT Records, Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en eutopsy performed? SEIZURES hes 1 Yes 2 DXN0 1 Yes 20 No this certificete Division of Vital Be 25. Was case rafarred to madical examiner? 26. Place of Deeth (Check only ona) Hospital: 1 Nonpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No uneral 27. Menner of Death 28d. Dascribe how Injury occurred 28e. Deta of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? Aftert 5 Pending invastigation Hospital or Attanding 1 Naturel within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Spacify) 4 Homicida 29a. Certifier 1 Certifying Phyelclan: To the best of my knowledga, death occurred at tha tima, date and placa, and dua to tha cause(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, daeth occurrad at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signeture end title of certifier 29c, License number 29d. Dete signed (Month, Dey, Yeer) i hus 97000 JANUARY 25, 1997 3 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) ST. PAUL Street, BALTIMORE, MD ZIZOZ 651-D SAADIA 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State ha Davidson-Randall JAN 29 1998 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death DOROTHY. B. ZIMMERMAN Month 10-03AM January 4b. City, Town, or Location of Death 4e. Facility Neme (If not institution, give street end number) 4c. County of Deeth Columbia Howard Howard County General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1□M 2⊠F Deys Yrs. 220-24-4773 67 Feb 19, 1930 Maryland Usuel Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Maryland | Baltimore Granite 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 10435 Davis Ave. 21163 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3₺ Widowed 4 Divorced White 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Oakview Treatment Ctr. Elementery/Secondery (0-12) College (1-4or 5+) & Martins West 10 years 0 Cook 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elmer Robinson Irene Redman 19a. Informant's Name/Reletionship (Type, PrInt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Susan Meekins (Daughter) 10435 Davis Ave. Granite, MD 21163 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial 1-31-98 Timonium, Maryland re of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, Maryland 21133 23a. Part Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, now, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) Amputation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Intieted events resulting in death) Last Due to (or as e consequence of): 1/A sular Dheral Due to (or es a consequence of): Diabetes De pen dant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24e. Was an eutopsy performed? completion of ceuse of death? 1□Yes 22 No 1 Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner P.O. Box 68760 The law requires that the death certificate Records, Division of Vital Hospital or Attanding Physician: To the Hospital or Attending Physi-within 24 hours efter daeth. To the Funerel Director: After this c completely filled in by the funeral dir

Physician/Medical by Completed Be Certification: To Medical

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1 and 2 should be filed within 72 hours efter. Heelih and Mantal Hygiana. Haelih and Mantal Hygiana. am 27 Is marked other than "natural", or Nathar thaumatic avent, Ile Widdial Earn

or other t

permit. Pege Depertment of Important: If any injury or

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the Maryland

death

21215-0020

Baltimore, Maryland

25. Was case referred to medical Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 28e. Date of Injury (Month, Day Year) 28c. injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 1 Naturel N)A 5 Pending investigation NIA NA 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide NIA NA 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, end due to the cause(s) end manner es stated.

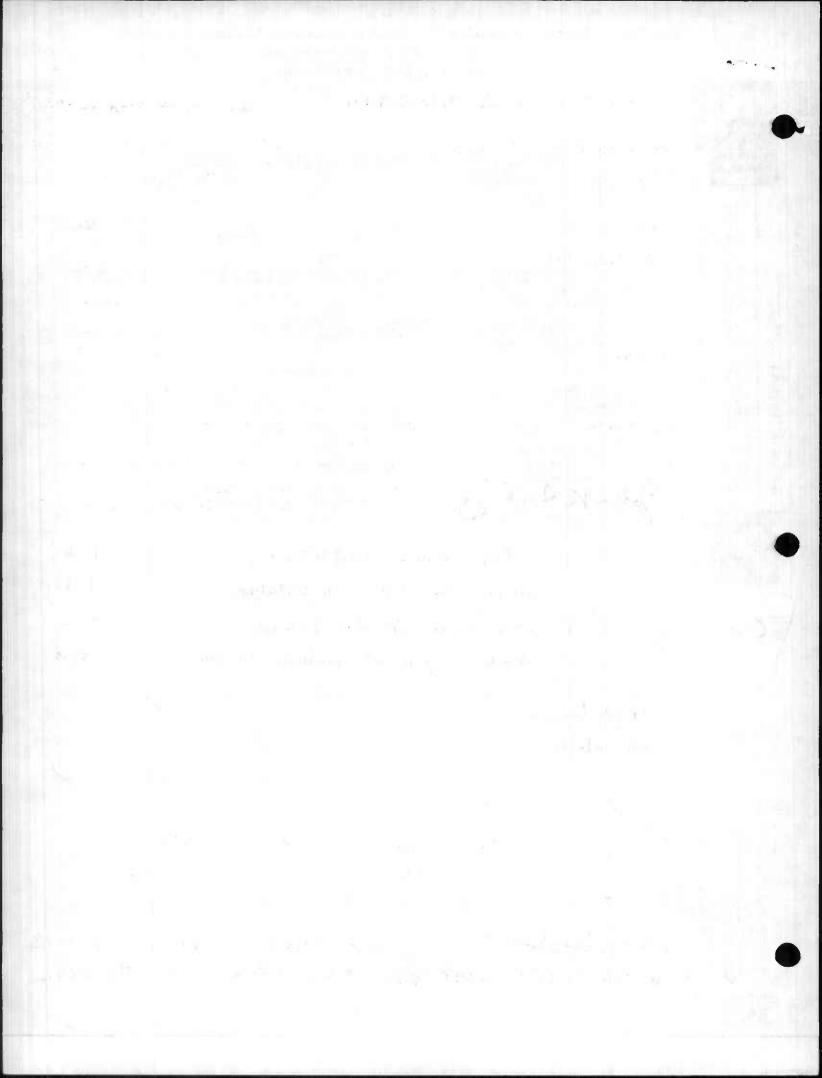
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) end manner stated. 29a. Certifier 29b. Signature and title of communications 29c. License number 29d. Date signed (Month, Day, Year) D. 30469 January

ted cause of death (Illam 23e) (Type, Print) 7 100: Ellicott Cay. on who complet MD.21042' . Name and eddress of

State Registrar

0

31. Date filed (Month, Day, Year) 32. Registrer' Signature 291998 who Davidson-Randall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Doris Zahn Jan 28 4:17 an 98 4a. Fecility Neme (If not institution, give streat end number) 4b. City, Town, or Location of Death 4c. County of Deeth | Catonsville
| If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Months Deys Hours Min. | (Month, Dey, Yeer) Care Center Charles town Bultimord 5. Social Sacurity Number Birthpleca (State or Foreign Country) 6. Sax 7. Age (In yrs. last birthdey) Sax 1 M 2 F 220-46-0155 83 Yrs. 10/28/1914 MD Usuel Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Catonsville 10e. Street and Number 10g. Citizen of Whet Country? 9 Stonespring Ct. 21228 USA 12. Was Dacedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ② No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced Specify: White 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Elwood Stansbury Alice White 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 9 Stonespring Ct. Catonsville, MD 21228

20b. Plece of Disposition (Nemeror Camefery, cremetory or other plece) Dr. Richard S. Zahn/Son 20a. Method of Disposition 1 Burial 2 □ Cramation 3 □ Removel from Stata 4 Donetion 5 Other (Specify) Woodlawn Cemetery 01/30 Balto. Md. 21. Signetura of Juneral Sarvice Licensage 22. Name and Addrass of Fecility David J. Weber Funeral Home 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heart failure. List only one cause on each line. Immadiate Ceuse (Finel Uro Sepsis

Due to (or es e consequence of) day 5 diseese or condition resulting in deeth) Sequentially list conditions, if any, leeding to immadiate cause. Enter Undarlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or es a consaguance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus 24b. Were eutopsy findings available prior to completion of ceusa of deeth? 24e. Wes en eutopsy performed? Vascular Accident 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Menper of Deeth 28a. Dete of Injury (Month, Dev Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 12 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Physician /Medicai Examiner Records. Dorus Vital Name:

Attanding Physician: The law requires that the death certificete After this certificate hes

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

MD

Funeral

Director

Peges 1 end 2 should be filed within 72 hours efter death with the Marylen ment of Heelth end Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

permit. Pege Depertment of Important: If any Injury or once.

21215-0020

Baltimore, Maryland

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nours efter death.

neral Director: After this of filled in by the funeral di To the Hospital o within 24 hours of To the Funeral D completely filled i

> State Registrar

Physician/Medical Examiner þ Be Completed 2 Medical Certification:

> 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) salazar

4 Homicide

29b. Signeture end title of certifier

29a. Certifier (Check only one)

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

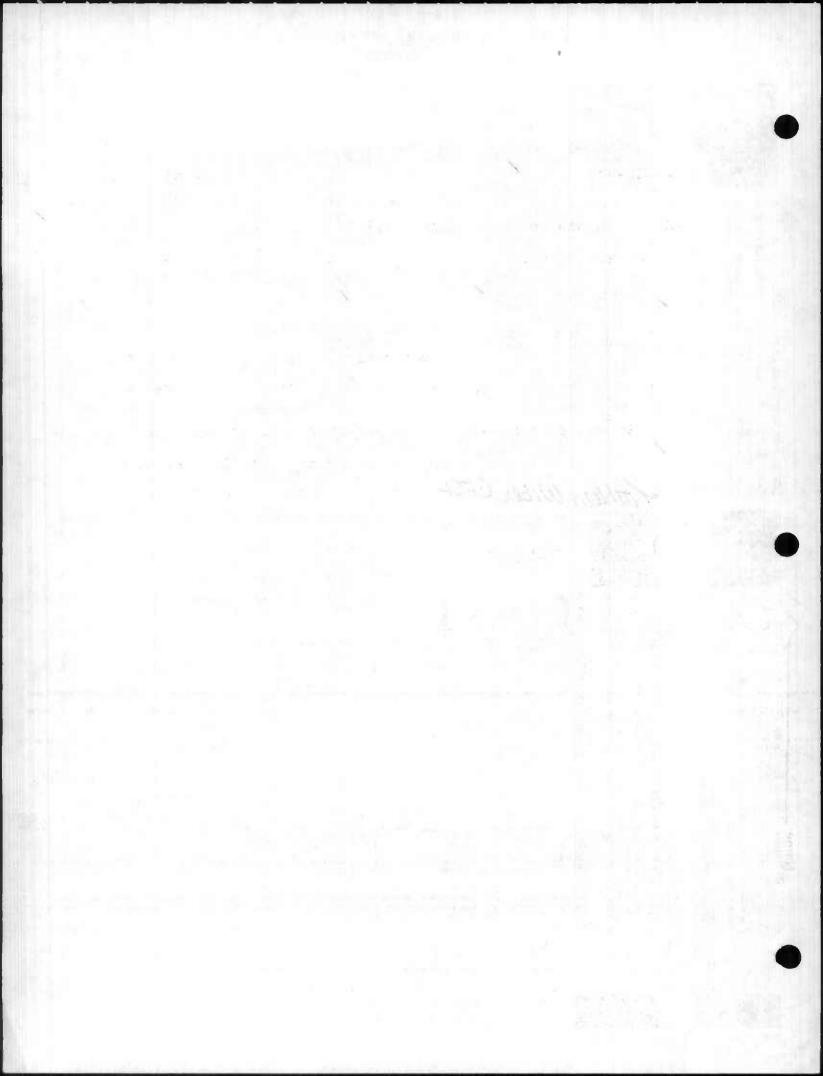
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

29c. Licensa number

29d. Dete signed (Month, Dey, Year)

711 Maiden Choice lane, Catonsville, MD, 21228 Andres 31. Deta filed (Month, Dey, Year) 32. Registrer's Signetura

Julia Avidson-Mandall



FOR

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - STATE REGISTRAR		OWNE OF I	CI	ERTIF	ICATE C	F DEA	TH	MENTA	REG. NO.	E		
1. DECEDENT'S NAME (First,								2. DATE	OF DEATH	v	YEAR	3. TIME OF DEATH
PHILLIP A		ZOPPO,	SR.					JAI		199		6:27 P.M.
4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In yrs. las	.,	IF UNDER 1 YEAR	-	24 HRS.		OF BIRTH		8. BIRTH Countr	PLACE (State or Foreign
214-12-2762		1× M 2 □ F	75	YRS.	WONTING DAT	o moons	milit.		27/22		1400	YLAND
9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY, TOW	N OR LOCATI	ON OF D	EATH		9c. COU	NTY OF D	EATH
CARROLL GEN	IERAL I	HOSPITAL			WEST	INSTE	R			C	ARROI	L
10a. STATE	10b. COUNTY	Υ		10c. CIT	Y, TOWN OR LO	CATION						10d. INSIDE CITY
MD	BA	ALTIMORE		D7	ARKVILL	r.						LIMITS? 1 YES 2 NO
10e. STREET AND NUMBER	<u> </u>	DATE FOR CO		1 1 7	TOTAL TOTAL	101. ZIP COD	E			10g. CIT	ZEN OF W	THAT COUNTRY?
8011 HIGH	POTNT	ROAD				212	27				USA	
11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U.S. AR	MED	13. WAS I	DECENDENT (F HISPAI	NIC ORIGI	N? (Specify Yea	or No-	14. RACE	— American Indian,
1 Never Married 2 X 3 Widowed 4 Divo		IF YES, GIVE V	YES 2 X	VO.		specify Cuba YES 2 X NO			Rican, etc.)		Specif	, White, atc.
												WHITE
(Specify only	highest grade	completed)	(G	CEDENT'S ive kind of Do NOT us	WOUND OCCUP	ATION most of working	ng	168	. KIND OF BUS	INESS/INI	DUSTRY	
Elementary/Secondary (0	-12)	College (1-4 or 5	*)									
6th GRADE	iddle, Last)			BRICK	MASON		HED'C ALA	ME /Final	CONTRA Middle, Maiden			
PASOUALE	ZOPPO)				1	RGA					
19a. INFORMANT'S NAME (7)			191	b. MAILING	ADDRESS (Stre				MERCUF		Codel	
ANNA ZOPPO					HIGHPO				CIMORE,		212	3/
20s. METHOD OF DISPOSITI			20b. PLACE	ANDDATE	OF DISPOSITION		/AD	DAL			City or Ton	
1X Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		oval from Stata	cemetery, cre	AND	MEMORI.	AL PAR	ĸ	1/			ALE,	
21. SIGNATURE OF PUNERAL	SERVICE LIC	ENSEE	/		22. NAME	AND ADDRE	SS OF FA	CILITY			ן שטאי	ND
1 de 4	8.	16 0/							IOME, P			
23. PART I. Enter the di	seases, or c	omplications the	t caused the de	ath. Do r	ot enter the	LOCH	RAV	EN E	SLVD.	TOWS	ON	MD 21286 Approximate
anock, or ne	part ranure.	List only one cau	ne on each line			oou or uy	ing, auto		biac of feapil	etory an	081,	interval Between
iMMEDIATE CAUSE (Fin disease or condition	01	O.i.		1.1	6.5.4							Onset and Death
resulting in death)		BUE TO	OR AS A CONSEC	DUENCE O) 2 () D:							decars.
Sequentially list condition if any, leading to immediate		DUE TO	(OR AS A CONSEC	UENCE O	F):							
cause. Enter UNDERLYII CAUSE (Disesse or Injur		с										
that initiated events resulting in death) LAST		DUE TO	(OR AS A CONSEC	VENCE O	F):							
Treating in dodain, Excel		d										
PART II. Other aignifican	nt condition	a contributing to	death but not n	esulting	n the underly	ring cause g	iven in	Part i.	24a, WAS AN /	WTOPSY	24b.	WERE AUTOPSY FINDINGS
									PERFORI	-		AVAILABLE PRIOR TO COMPLETION OF CAUSE
									1 1 163 2	PHO		OF DEATH?
DID TOBACCO US	SE CONTR	RIBUTE TO CA	USE OF DEA	TH YE	S NO	□ UNC	ERTAIN	VE				T TES Z LL NO
25. WAS CASE REFERRED TO EXAMINER?	MEDICAL		26. PLAC	E OF DEAT	H (Check only o	ne)						
1 TYES 2 NO		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER: 4 Nursing H	ome 5 🗆 Re	sidenca	8 🗆 Othe	r (Specify)			
27. MANNER OF DEATH		28a. DATE OF (Month, D		28b. TIM		INJURY AT WORK?		28d. DES	CRIBE HOW IN	JURY OC	URED	
	Pending nvestigation	1110	**L 4M*			YES 2	NO					
3 Suicide 8 C	Could not be	28s. PLACE O building,	F INJURY - At horate. (Specify)	me, farm, s	treet, factory, o	Hice		28f. LOC	ATION (Street ar	nd Number	or Aural A	oute Number,
4 Homicide d	letermined							,	a. tarri, dialoy			
290. CERTIFIER (Check only	FYING PHYSIC	CIAN: To the best of	my knowledge, de	ith occurre	d at the time, d	ata and place,	and due	to the cau	se(a) and man	ner as stat	ed.	
one) 2 MEDIC	CAL EXAMINE	R: On the basis of a	kamination and/or i	nvestigatio	n, in my opinior	, death occur	ed at the	time, date	and place, and	due to th	e cause(a)	and manner se stated.
29b. SIGNATURE AND TITLE	OF CERTIFIER					29c. LICE	NSE NUN	4BER		29d. DAT	SIGNED	(Month, Day, Year)
M. No	Sir	MD				DE	STI	1			1128	198
30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEATH (ITEM	1 27) (Туре,	Print)							. 10
Mokhtar a	Jusir.	904	Washin	wof.	Rd, S	vile 1) ,	West	tmiwite	v. r	ND	21157
31, DATE FILED (Month, Day, Y	1998		H'SDSIGNATURE?	7.00								

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

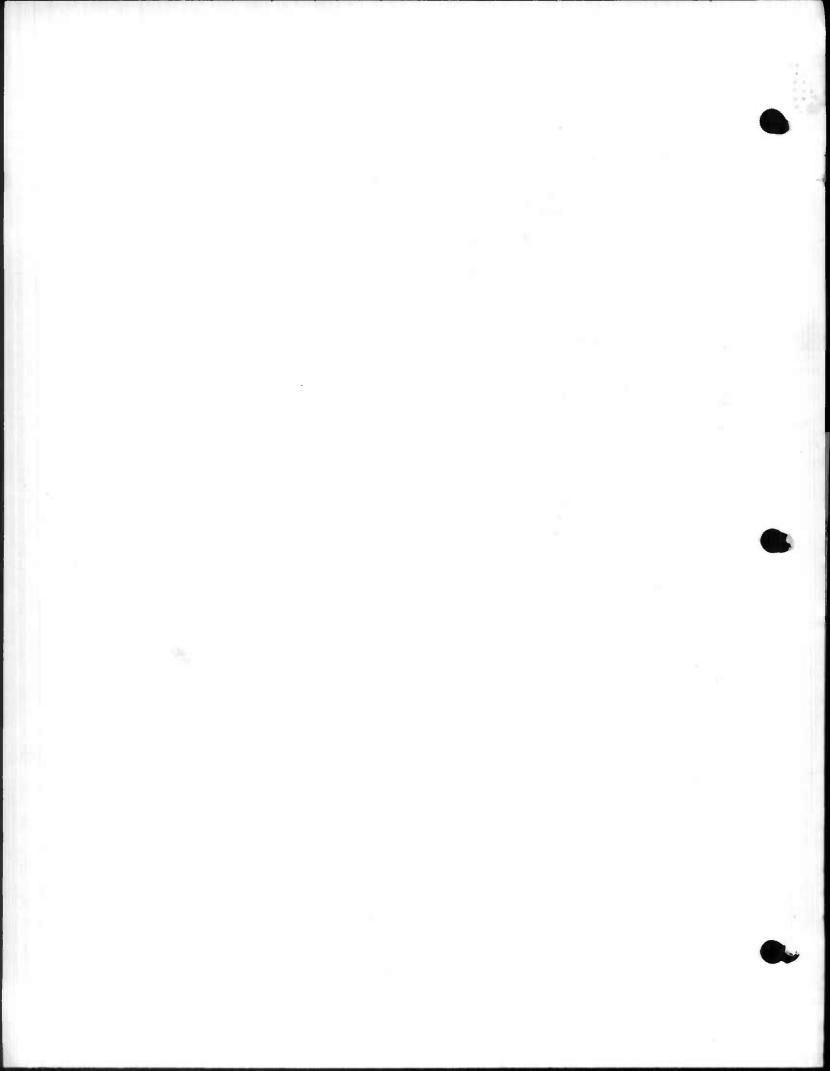
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. (BOX 68760)

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

JAN 29



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Deeth Hemayehu Month adau 4e. Fegility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Nedica (anki Balhmore H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | Min. | Month, Dey Year) | 9 5 9 5. Social Security Number 7. Age (In yrs. lest birthdey). 3 8 Yrs. Birthplece (State or Foreign Country) Sex 1 M 2 F Ethiopia Usuel Residence of Deceden 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No PG **Beltsville** Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3517 Cherry Hill Court 20705 Ethiopia 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Yes 2 ☐ No Specify 3 ☐ Widowed 4 ☐ Divorced **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12th +02 Nigerian Embassy Secretary 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Abate Alemayehu Meskerm Wogayhu 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Diana Tegegn/cousin 3517 Cherry Hill Ct. Beltsville, Md. 20705 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burlal 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Ethiopia Estfhsos unk. 21. Signature of Fuperet Service Licensee 22. Name end Address of Fecility Frazier's Funeral Home, Inc. 389 Rhode Island Ave., NW Wash., DC 20001 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Batween Onset and Death Immediete Cause (Final diseese or condition resulting In death) 10 ns S Due to (or es e consequence of): ced Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown to 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? 1 🗆 Yes 21XN0

Physician /Medicai Examiner

physiclan and s the buriel-transit

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signed by t

certificate hes

this funeral

filled in by

of or Attending F after death. Director: After After

Hospital
 24 hours a
 Funeral D

To the F within 2

Be

To

Certification:

Medicai

Box 68760

Records, P.O.

Division of Vital

Physician

/Medical

Director

Funerai

þ

Completed

Be

none

Examiner

Funeral Director

7 is marked other than "natural", or Items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

nit. Peges 1 and 2 should be filed within 72 hours after cartment of Health and Mentel tyglene. ortant: If item 27 is marked other than "natural", or Itel injury or other thatmatic event, the Medical Example.

permit. Pege Department of Important: If any Injury or

Baltimore, Maryland 21215-0020

with the Maryland

death v

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Physician/Medical þ Completed

4 Homicide

31. Date filed (Month, Dey, Year)

JAN

Pert II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I.

1 Yes 2 No

25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Inpatient 2 ER/Outpetient 3 DOA

27. Maprier of Death 28e. Date of Injury (Month, Dey Yeer) 28h Time of 5 Pending Investigation 2 Accident 6 Could not be determined 3 Sulcide

28d. Describe how injury occurred 28c. injury et Work? 1 Tyes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Exeminer: On the bests of exeminetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License numbe

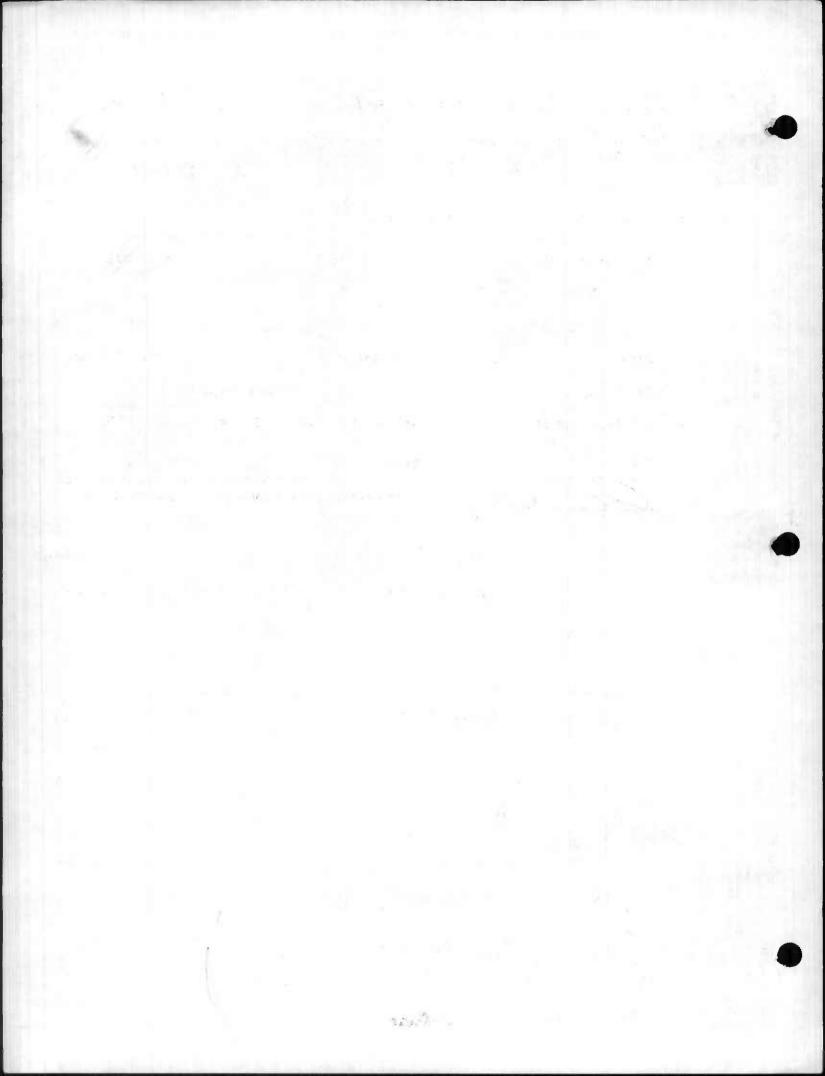
1 3 1998

29d. Dete signed (Month, Dey, Yeer)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

301 St. Paul 1 Ballimore cy Medical Cor, 32 Registrer's Sig Jall Shudeon R

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED # 4a.PER DOCTOR P.G.C. 1-14-98 cr 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth 3. Time of Death **Physician** JANUARY LILLIE ADAIR 1998 2:25AM /Medical 4a. Fecility Nema (If not institution, giva street and number) GLADYS NOON SPELL 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MAN Cheverly Prince George's Hospital Center Prince George's 5. Social Sacurity Number If Under 1 Yaar If Under 24 Hrs. 9. Birthplece (State or Foreign Country)
S. Carolina 7. Age (In yrs. lest birthday) **Funeral** Deys 1 M 2 F 92 Yrs. 579-10-4526 Director Usuel Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City. Town or Location 10d. fnside City Limits r than "natural", or items 23e or 28e-f show Md. P.G. Landover 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8954 Continental Place 20785 U.SA. Funeral 12. Wes Dacadent Ever In U.S. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxicen, Puerto Rican, etc.) Raca - American Indian, Bleck, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: P Black 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Domestic Private Industry 4th is marked other permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If them 27 is marked other any Injury or other traumatic event. 17, Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be Milton James Hattie Fuller 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Hattie L. Adair/Daughter Same as # 10 above 20a. Method of Disposition 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stete cemetery crematory or other plece)
Balt-Wash. Crematory 1 ☐ Burial 2 ØCremation 3 ☐ Ramoval from Stete 1/9/98 Laurel .Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility H.S. Washington & Sons Co 4925 Burroughs Ave., N.E. 21. Signeture of Funeral Servica Licansae Sons Co., Inc. W. Si & any 23a. Part1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Baby Onset end Deeth **Physician** /Medical Immediete Cause (Final disaese or condition resulting in deeth) **Examiner** Examiner Zementia The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest ettending physician and for use es the burial-tren Box 68760, elinarasc Physician/Medical Due to (or as a consequence of) P.O. I Pert II. Other eignificent conditiona contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes Ø No. 3 ☐ Probably 4 ☐ Unknown Records, Be Completed by 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24e. Wes an autopsy performed? 1 Yes certificete Division of Vital Hospital or Attending Physician: 24 hours efter death. 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: Sursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this eral Director: After thi 27. Menner of De 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not ba 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, straat, factory, office building, etc. (Specify) 4 Homicide To the Hospital ithin 24 hours e ledicai 29a. Certifier Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. (Check only 29b. Signeture end titla of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 6001 Landener Rd Chevaly MD 20785 ndar MD

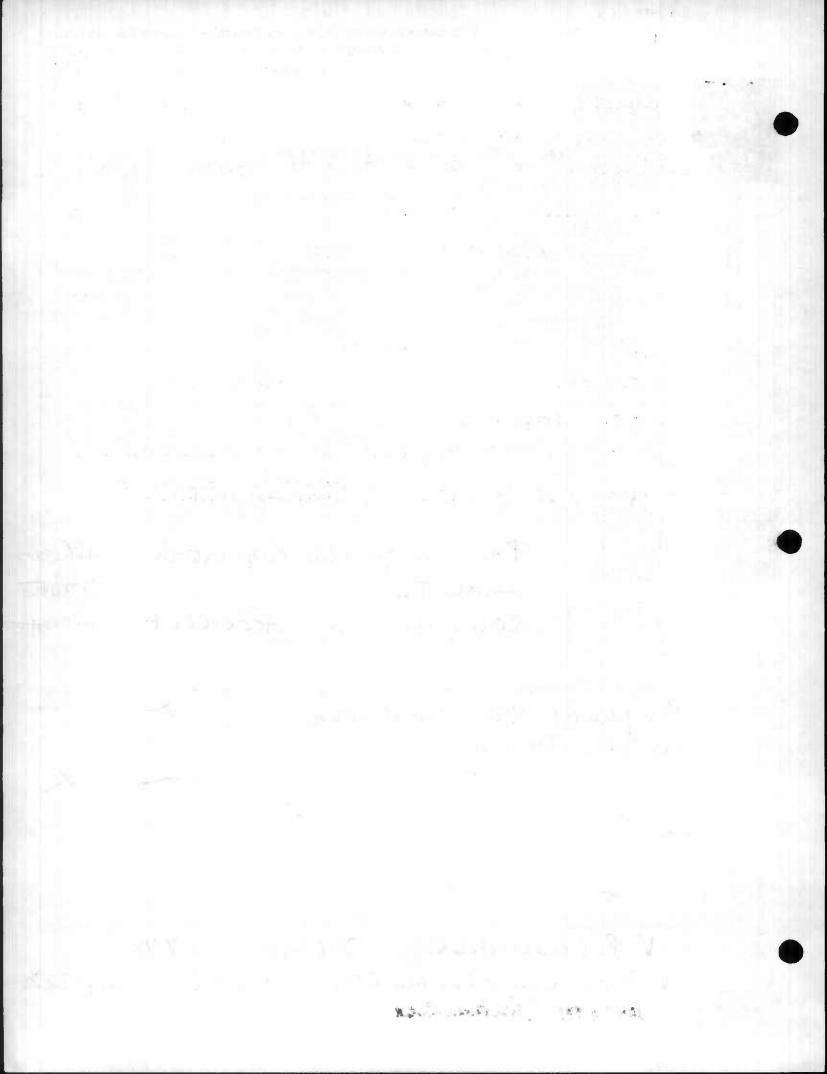
Registrer's Signature

Registrar

State

31. Dete filed (Month, Day, Year)

JAN 14 1998

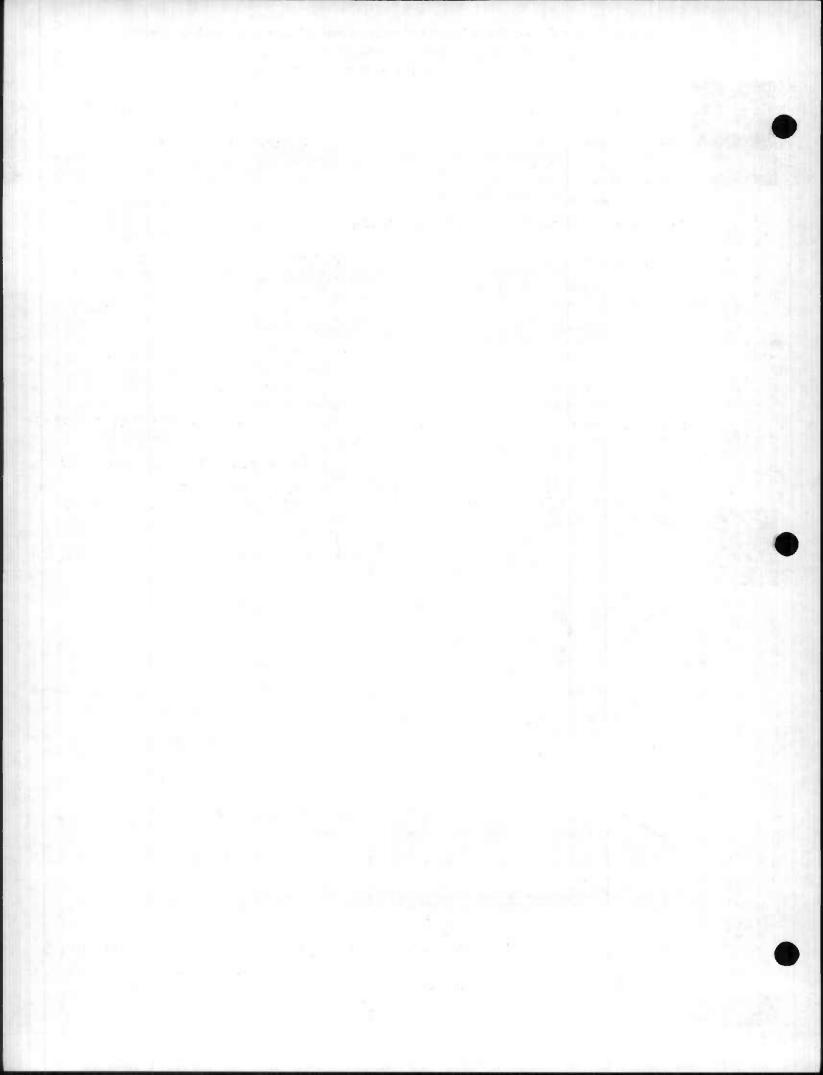


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

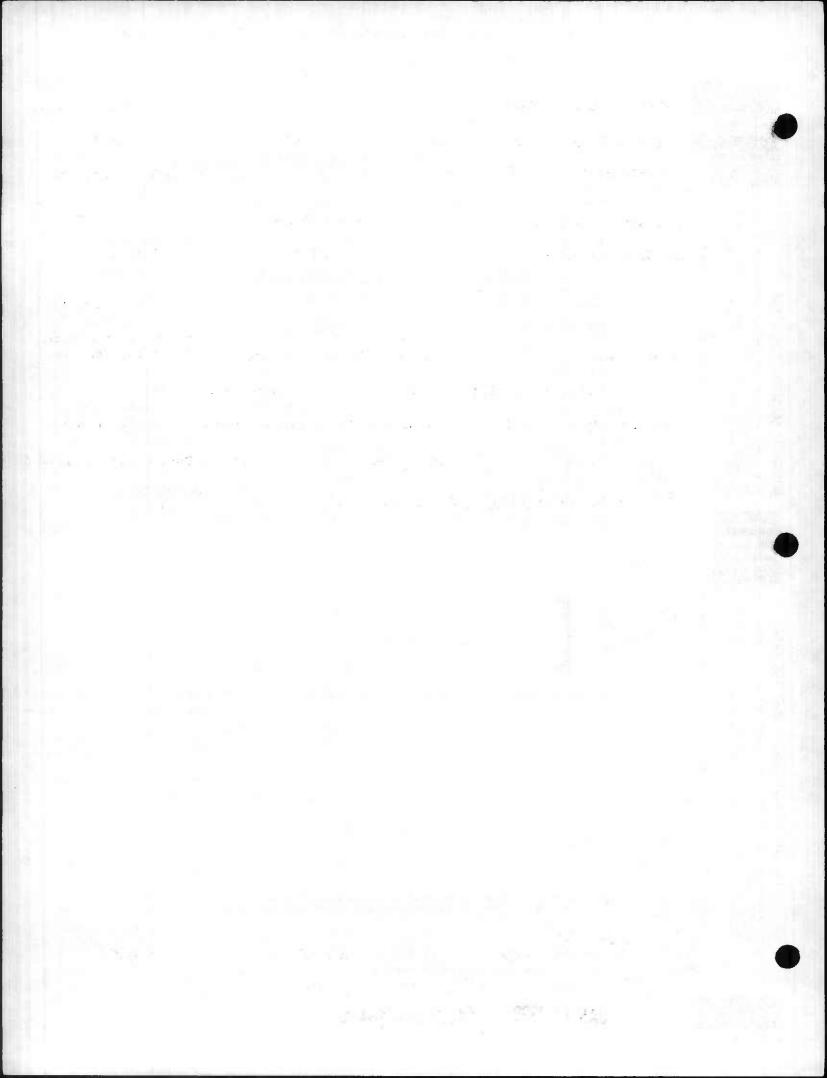
Certificate of Death Reg. No. " 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month MARGARET AMELIA BERNARD JANUARY 19, 1998 9:45 AM /Medical 4a. Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GARRETT COUNTY MEMORIAL HOSPITAL GARRETT OAKT.AND 5. Social Sacurity Number If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year, SEPT 14, 1 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1□ M 2X F 235-32-6565 78 MARYLAND **Yrs** 1919 Director Usual Residence of Decedant permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Marylend Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Ned call Examiner must be notified at 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yas 2 No Director MD GARRETT MT. LAKE PARK 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 701 DEER PARK AVENUE 21550 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ∑ No If Yas, Giva Yeer or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - American Indian, Black White atc. 1 ☐ Naver Married 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highest grada completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) HOMEMAKER OWN HOME 17. Fethar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be BERCHARD BITTINGER H. AMELIA KRAUSE 19a. informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) LEE BERNARD - HUSBAND 701 DEER PARK AVE. MT. LAKE PARK, MD 21550 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Deta 1K Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Spacify) 1/21/98 ZION CEMETERY ACCIDENT, MARYLAND 22. Name end Addrass of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batw Onsat and Death Physician Immediata Cause (Finel disease or condition resulting in death) /Medical Congestive Heart Failure 2 years Examiner Dua to (or as a consaguanca of): Examiner or Attending Physician: The law requires that the death certificete be executed the buriel-transit Sequentially list conditions, if any, laeding to immadiata ceusa. Enter Underlying Causa (Disaasa or Injury that intietad evants rasulting in death) Lest end Dua to (or as a consequence of): Box 68760. physician Physician/Medical Dua to (or as a consequence of): 80 for use signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Records, P.O. 23b. Did tobscco use contribute to the cause of death? 1 ☐ Yee 2 ☐No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus Be Completed by 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? pege 2 should peen hes 2X No certificete 1 ☐ Yas 2 ☐ No Division of Vital funeral director, 25. Was cesa rafarrad to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 Mopatiant 2 ER/Outpetient 3 DOA Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yas 2 No this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred After 1 Natural 5 Panding To the ruces effer death.

To the Funeral Director: Aft 1 ☐ Yas 2 ☐ No Investigation 2 Accident 6 Could not be datarmined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 Homicida Hospital 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of combine 29c. Licansa number 29d. Data signad (Month, Day, Yaar) 1/19/98 D27205 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Karl E. Schwalm 311 N. 4th St., Oakland, Md 31. Data filad (Month, Day, Year) 32. Registrar's Signature State JAN 2 0 1998 Registrar

		1 December Name /First Middle 1	Cert	ificate of	Death		. No.	440
Physi	cian	Decedant's Nama (First, Middle, Last)				2. Data of Death Month	Day Yaar	3. Tima of Death
/Med	dical	Noah S. Beachy 4a. Facility Nama (If not institution, give street and number)			4b. City, Town, or Lo	cation of Death	8 1998 4c. County of Dea	4:45 Am
Exam	niner	THE SECTION AND ADDRESS OF THE SECTION ADDRESS OF THE SECTION AD						
Funera	al le	758 Springs Road 5. Social Sacurity Number 6. Sax 7. Aga	(In yrs. last birthday)	If Under 1 Year	Grantsv If Under 24 Hrs.	8. Data of Birth (Month, Day, Y	Garrett	thplace (Stata or Foraign
Directo		180-28-0217 X ^{DM 2DF}	88 Yrs.	Months Days	Hours Min.	(Month, Day, Y	(ear) C	ountry) nnsylvania
9		Usual Rasidance of Decedant	10.00		A:			
show	2	10a. Stata 10b. County	10c. City, Town or Loca					10d. Insida City Limits 1 ☐ Yas 2 ☐ No
the M	Director	Maryland Garrett 10e. Street and Number	Grantsvi					
with post	ā			10f. Zip Coda		10g	. Citizan of What C	ountry?
eath	era	758 Springs Road 11. Marital Status 12. Was Dacedant E	Evar in U.S. 13 W		536 lispanic Orlgin? (Spe	oify Vas or No.	USA 14. Race - Ame	arican Indian
Baltimore, Maryland 21215-0020 pennit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Depertment of shalth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, ms Mexical Examiner must be notified.	by Funeral	Armed Forcas? 1 Nevar Marriad 2 Married 1 Yas 2 N If Yas, Giva 3 Widowed 4 Divorced Armed Forcas? 1 Yas, 2 N If Yas, Giva Yaar or Datas:	lo _	Yas, specify Cuba □ Yas 2000	lispenIc Orlgin? (Spe an, Maxican, Puarto Specify:	Rican, atc.)	Black, Whi	
5-0 22 ho	Completed by	15. Dacedant's Education	16a. Deceda	nt's Usual Occup	ation	16	ib. Kind of Businass	
d within giene.	npie	(Specify only highast grada complated) Elamantary/Secondary (0-12) College (1-4or 5-	+) (GIVA KI	O NOT usa retired	ation during most of worki d)	ng		
d 21 filled w Hygien ther th	S	8	Self	-emplo				lership
Maryland d 2 should be file th end Mentel Hy 7 is merked other traumatic event	Be	17. Fathar's Nama (First, Middla, Last)			18. Mothar's Nama		idan Sumama)	
aryla should in and Men	2	Simon C. Beachy	100 100		Sarah 1			
Ma d 2 sl th end 7 la n		19a. Informant's Name/Ralationship (Type, Print)			and Number or Rura			
1 and Health		Simon D. Beachy 20a. Mathod of Disposition	20b. Place of Disposition cematary, crama				c. Location - City or	MD 21536
Peges nent of Intil If Ite		1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify)	Viceses services					
Baltimore, semit. Peges 1 ar Depertment of Hea mportant: If Item.		21. Signatura of Funara Service Licensee	Mt. View	V Cemet Nama and Addra		.21,98	Salisbu	ry, PA
Balt permit. Depente Imports any Inju		NOW NO) Ne	wman F	uneral F	Homes, I	P.A.	
		23a. Part1. Enter the disaasa, or complications that causad shock, or heart la lura. List only one cause on each line	tha daath. Do not antar	O. Box	275; Gr	rantsvi	lle, MD	21536 Approximata
Physician /Medica Examine	i r	Immediata Causa (Final disaasa or condition rasulting in daath)	1	tent	Parlu	Q.		Intarval Batween Onset and Death
nsit	Examiner	ь		9				
ox 68760, certificate be axecuted ding physician and use es the burial-transit	Exa	Sequentially list conditions, if any, laading to immadiate cause. Enter Undertying Cause (Disease or injury	Dua to (or as a conseque	ance of):				
68760, rificate be axe physician a se the burial-	edical	linat initiated avants	Dua to (or as a consagua	ance of):				
68 rtifica ng ph		rasulting In death) Last						
Box 6 Jeath certific attending	an	d						
- 0 0 %	Physician/M	Part II. Other algnificant conditions contributing to death but	t not rasulting in the und	larlying causa giv	an in Part I.	23b. Did toba	acco uae contribute	to the cause of death?
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Of Vital Physician: The cartificate rai director, pa	Be	25. Was case referred to medical axaminar? 1 Yas 2 No Hospital: 1 I I Inceptan		o Doub Oth	26. Placa of Death			
O # # 5	7: To	27. Manner of Death 1 Project Survey	ent 2 ER/Outpatient y 28b. Tima of	3□ DOA OIII 28c. Injur	4 U Nursing Hor	na 5 M2 Hasidano 28d. Dascribe how	ce 6 Other (Spe	ocify)
Vision o Attending Ph ir death. ector: After thi by the funeral	atlor	1 ☐Natural 5 ☐ Panding (Month, Day) 2 ☐ Accident invastigation	Yaar) Injury		k? Yas 2 □ No			
Division or Attending efter death. Director: After	Certification:	3 □ Suloide 6 □ Could not be	ry - At homa, farm, straa	it, factory, office	- 2	28f. Location (Strat	at and Number or R	ural Routa Number,
od in page of in	Cer	building, atc.	. (Эрөспу)			Only of Town,	Siala/	
d hour	edical	29a. Cartifiar 1 ☐ Certifying Physicien: To the bast of 2 ☐ Medical Examiner: On the basis of a	f my knowladga, daath o	occurrad at tha tin	na, data and place, a	and dua to the caus	sa(s) and mannar a	s stated.
Divisio To the Hospital or Attendif within 24 hours effer death. To the Funeral Director: Al	Med	one) and manner stet	ed /					
Wit To	-	29b. Signatura and titla of certifiar	00	29c. Licans	a number	29d	Data signed (Mon	m, Uay, Year)
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	1	30. Nama and addrass of person who completed cause of de	ath (tam 23a) (Type, Pr	cipt)	11- m		21536	
	tate	31. Data filad (Month, Day, Yaar) 32. Registra	r's Signatura	~ Y HA + 50	TILL IV	0	11336	
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	÷	Decedant's Nama (First, Middle, La	et)		Certifica	te of i	Death		2. Deta of Dee	leg. No.		3. Time of Death
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/Media Examir		4a. Facility Nama (If not Institution, giv	a street and number)			4	b. City, Tow	vn, or Loc	ation of Death			7:22 PM
		Calvert Manor H	ealthcare	Center			Ris	ing	Sun		Ceci	1
Funeral Director		217 12 0403	Sex 7. Aga □M 2以F	a (In yrs. last) 92		Days	If Under 2 Hours	Min.	8. Data of Birtl (Month, Day Aug. 3	, Year) 1905	9. Birthp Cour Ma	laca (Stata or Foral try) ryland
8 ₩		Usual Rasidance of Dacedent 10a. Stata 10b. County		10c. City, To	own or Location						1	0d. fnslde Clty Limit
	tor	Maryland Harfo	rd		Hav	re de	e Grac	e				1XX as 2□N
3a or 28	Funeral Director	10e. Street end Number 500 Congress Aven	ue		10f. Zi	p Coda 21	L078			10g. Citizen of	What Cour	ntry?
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ked o	To Be	Thomas	Franklin	Lawre	nce				Jane C		5177	
to Health and Manual Hyglene, it of Health and Manual Hyglene, if from 27 is marked other than or other traumatic event, the Manual Hyglene, the M		19a. Informant's Name/Raletionship (Type, Print)	1	9b. Malling Addras	s (Street					, Stata, Zip	Coda)
Department of Health e Important: If Item 27 is any injury or other tra-		Thomas D. Byrne	(son)		503 West			nue,	Lewes,	Delaw	are	19958
of He of He		20e. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐	Removel from State	20b. Placa came	of Disposition (Na tery, crametory or	ma of othar plac	ж)		Data	20c. Location	- City or To	wn, Stata
ment lant: I		4 □ Donation 5 □ Othar (Specifi	y)	Asb	ury Cemet	ery		1	/15/98	Port D	eposi	t,Maryla
Departimon in port	- 1	21. Signature of Funaral Sarvice Licar	nsee		22. Name e	nd Addres	ss of Fecility	n &	Son Fur	neral H	ome	
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his ce	2	1 Yas 2 No	Hospital: 1 ☐ Inpatie		Outpatient 3 D		4 La Qur	sing Hom	ne 5 □ Resid	enca 6 □Ot	her (Specif	y)
After t uner	inol ::	27. Manaar of Death 1 Natural 5 □ Pending	28a. Data of Injur (Month, Day	Year) 28b		28c. Injun Worl			8d. Dascribe h	ow Injury occu	rred	
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5 4 9	edical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of the best of and manner ste	axamination a	ge, death occurred and/or invastigation	et tha tim	na, data and pinion, daath	place, a	nd dua to tha o d at tha tima, o	ausa(s) and m lata and placa	enner as s	teted. the cause(s)
e Fune	Z	29b. Signeture end titla of certifier			29	c. License	, 1	0	2	29d. Dete sign	ed (Month,	Dey, Year)
within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	-		21.0			FS //	1411	(1)		///	5/49	<
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within 24 hou To the Fune completely fi	V	30. Name and address of geneon who of the state of the st	completed cause of de	S, UKI	o) (Typa, Print)				21078	///	7/10	



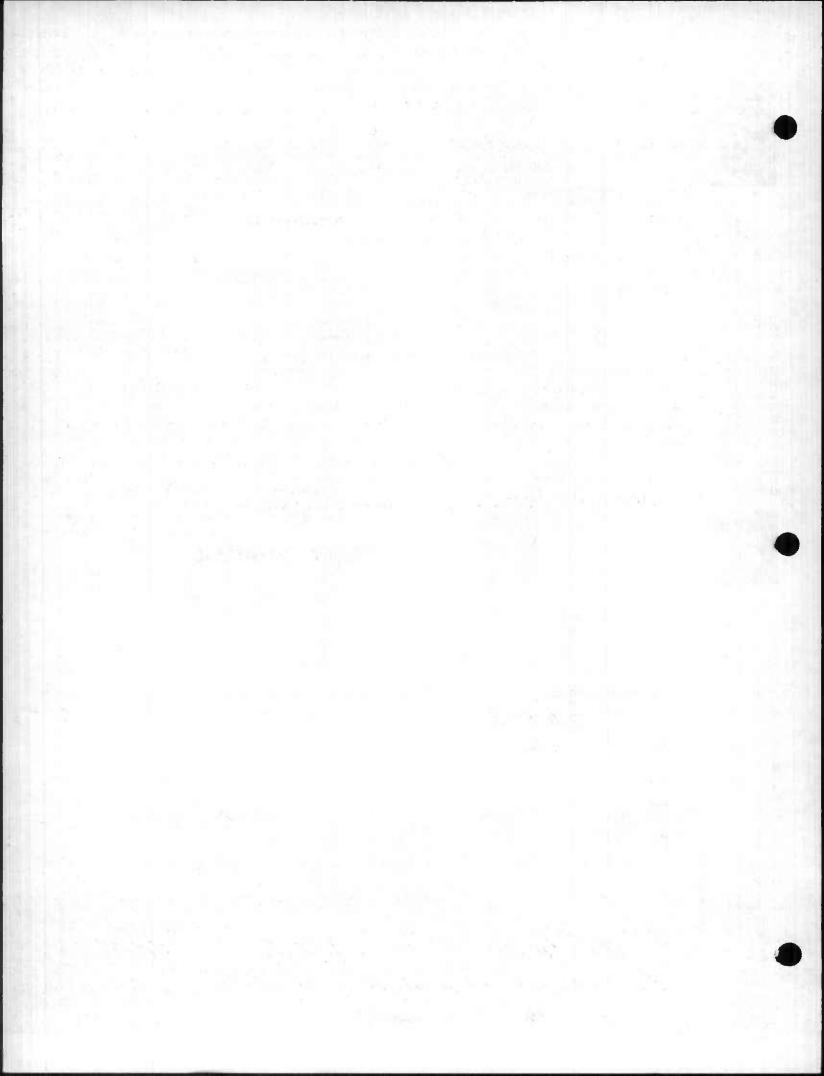
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year NORMAN REA BARNES 12, 2055 JAN. 1998 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Residence: 576 Theodore Road Cecil Port Deposit 5. Social Security Number 6. Sex 120 M/ 2 ☐ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Yrs. Director 215-36-8255 76 Feb. 9,1921 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Madeal Examins must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Ceci1 Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 576 Theodore Road 21904 U.S.A. Funeral 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 KUNo If Yes, Give Yeer or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1XXVever Married 2☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ▼ No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Rea's Delight Farm Elementery/Secondery (0-12) College (1-4or 5+) Two Years Port Deposit, Maryland Self-Employed Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Graham Barnes 0 Florence Rawlings 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Bowden (sister) 227 Parker Street, Carlisle, Pennsylvania 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Hopewell Cemetery 1/16/98 Port Deposit, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home attenson, Sr. Perryville, Maryland 21903-0188 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician MYOCARDIAL INFARCTION /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequenca of) Examiner requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. Physician/Medicai the Due to (or es e consequence of): attending for use as Pert II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobecco use contribute to the cause of death? 2 WKINA signed t Records, Be Completed by 24a. Wes en autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? been : 2 KNO 1 ☐ Yes No this certificate 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Was case referred to medical 28. Place of Death (Check only one) 1 Yes 2 No Other: 4☐ Nursing Home 5 Residence 6 ☐ Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of Injury 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Sulcide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end placa, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of cartifigs 29c. License number 29d. Date signed (Mongh, Day, Year) who completed cause of death (Item 23a) (Type, Print) 20 7. BIONDO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Sulia Davidson Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene ?

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al or		5/8-01-/605	ex □M 2 F 7. Age	(In yrs. last	Yrs. Month	hs Deys		8. Date of Birth (Month, De) Januar	6,1917	9. Birthplece	(Stete or Forei
		suel Residence of Decedent 0a. Stete 10b. County		10c. City, To	own or Location					10d. In	nside City Limi
Director			2-1-1	Wash	ington,	DC					Oves 2□N
Sire	10	0a. Street and Number			10f.	Zip Code			10g. Citizen of V	Vhet Country?	
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by Funeral	•	1. Maritel Status 1 Never Merried 2 Married 3000 Married 4 Divorced	12. Was Decedent Education Armed Forces? 1 ☐ Yes 2X Note of the Armed Forces of Detes:			specify Cut		Specify Yes or No- rto Rican, etc.)		e - American Inc kk, White, etc. : White	dien,
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State of Maryland / Department of Health and Mental Hygiene Q

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nuiiiii le	•	HARTLAND	NURSING	G HOME				ADELPH	т мат	OT AND	Priv	ce	George
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State of Maryland / Department of Health and Mental Hygiene

	2. Date of Death	3. Time of Deeth
ertificate of Death	Reg. No.	02248
artificiti of Floatiff and	monda riygiono	00010

Month

JAN.

4b. City, Town, or Location of Death

FREDERICK

Day

12, 1998

4c. County of Deeth

Physician /Medical Examiner
Funeral Director

the Meryland

filed within 72 hours after death with

Pages 1 and 2 should be fill ment of Health and Mental Hy Lint II from 27 is marked oth

Department of Important: If any injury or once.

Physician

/Medical Examiner

physician end the burial-transit certificate be axecuted

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page 2 s has cartificata

Box 68760

Division of Vital Records, P.O.

Attending Physician:

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Hospital 24 hours

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within 2 the

death.

Examiner

Physician/Medical

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Completed

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2

Certification:

edical

Baltimore, Maryland 21215-0020

"natural", or items 23a or

the Medical

4a Facility Name (If not institution, give street and number) FREDERICK COUNTY SQUARE SHOPPING CENTER 5. Social Security Number 7. Age (In yrs. last birthday) XXM 2□ F 578-58-0442 Usual Residence of Decedent

KENNETH ANTHONY BUTLER, JR.

If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days 10c. City. Town or Location LANDOVER

10f. Zip Code

20785

9. Birthplace (State or Foreign Country)
WASHINGTON, DC 10d. Inside City Limits XIXI Yes 2 □ No

11:15 AM

Directo 10e. Street and Number Funeral þ Completed

10e State

Be

7743 GREYMONT ST. 1 Never Married Married 3 ☐ Widowed 4 ☐ Divorced

10b. County

MARYLAND PRINCE GEORGES

1. Decedent's Neme (First, Middle, Last)

12. Was Decedent Ever in U,S. Armed Forces? 17 Yes 2 No If Yes, Give Year or Dates:

College (1-4or 5+)

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Race - American Indien Black, White, etc. Specify: BLACK

FREDERICK COUNTY

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 12TH

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COMPUTER TECH.

16b. Kind of Business/Industry PRIVATE

10g. Citizen of What Country?

UNITED STATES

17. Fether's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname) GLORIA JAMES BUTLER

KENNETH A. BUTLER, SR. 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

ROSALIND A. COLE BUTLER/WIFE 20e. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

P.O. BOX 796, GRAY COURT, SOUTH CAROLINA 29645 20c. Locetion - City or Town, Stete

WXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligens

HARMONY MEM. PARK CEM. JAN. 17, 1998 LANDOVER, MD

22. Name and Address of Facility
DUDLEY FUNERAL HOME MT. RAINIER, MD

EDWARD M. DUDLEY 0 | 3200 RHODE ISLAND AVE., MT.

Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

20712 Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Contact Gunshot Wound of Head Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Due to (or as a consequence of):

Due to (or es e consequence of)

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of ceuse of deeth? Yes 2 No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE

to Yes 2 □ No

28d. Describe how injury occurred

25. Wes cese referred to medical examiner? No Yes 2□ No 27. Menner of Death 1 Natural

2 Accident

3 Suicide

4 Homlcide

28e. Date of Injury (Month, Day Year) 5 Pending -12-98 investigation 6 Could not be determined

28b. Time of 1115 AM 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Banking

28c. Injury at Work? 1 Yes ≱€No

self-inflicted gunshot wound 281. Location (Street and Number or Aural Acute Number, City or Town, State Prival Square Shapping Frederick County Square Shapping Frederick, Ad

29a. Certifie (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

29c. License number

29d. Dete signed (Month, Day, Year)

O.C.M.E.

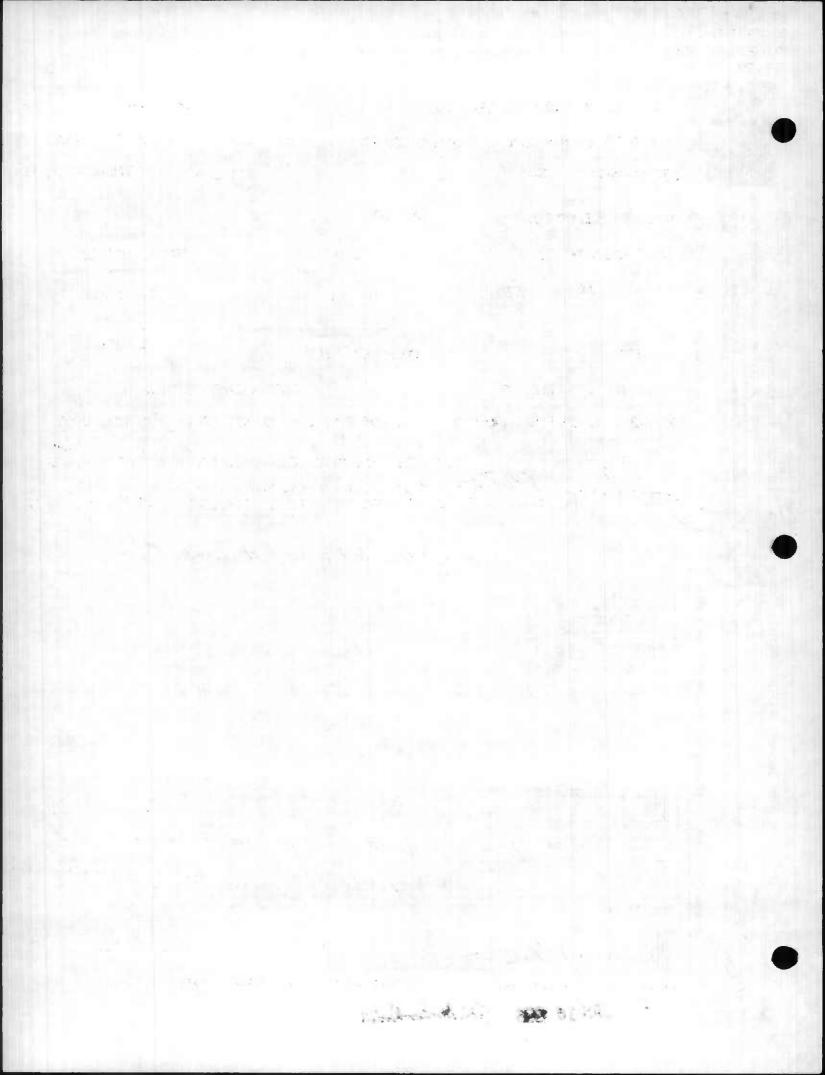
JAN. 13, 1998

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 Vennis m

Registrar

Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

				Ce	ertificat	e of	Death			Reg. No.	30	U	2249
Division		1. Decedent's Neme (First, Middle, Las	t)						2. Dete of De Month	eeth Dey	, ,	Yeer	3. Time of Death
Physic /Med		Maurice B	arnett						01	13	199		10:45a.
Exam		4e. Fecility Neme (If not institution, give	A STATE OF THE STA			4	b. City, To	wn, or L	ocation of Deet	th 4c.	County of	f Deeth	
		Calvert County Nu							ederick		Ca1	vert	
Funera Director		210-10-0002		lest birthday 4 Yrs.	Months	1 Year Deys	If Under Hours	24 Hrs. Min.	8. Dete of Bi (Month, Do January	rth e <i>y, Year)</i> 04, 1		9. Birthple Country Mary 1	ce (State or Fore y) and
pus *		Usuel Residence of Decedent 10e. Siele 10b, County	10e. C	ity, Town or L	ocation							100	d. Inside City Limi
he Maryla	Director	Maryland Anne Aru		racey'	s Lan		I						XXYes 2□
th with the 23a or 2		6380 Franklin Git	son Road		10f. Zip 2()779					J.S.A	net Countr	y?
d within 72 hours effer deeth with the Maryland Jiens. r than "naturel", or fferm 23a or 28a-f ehow the Macical Examiner must be notified at	by Funeral	11. Maritel Stelus 1 Never Merried 2 Merried 3 X Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:	J,S. 13	. Was Deced If Yes, spec 1 Yes	cify Cuba	lispenic Ori an, Mexicar Specity:	n, Puerto	ecify Yes or No Rican, etc.)		Bleck	- America , White, el Blac	IC.
72 ho	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dec	edent's Usu	el Occup	ation during mos	t of work	ina	16b. KI	nd of Bus	lness/Indu	stry
within ene.	hpidu	Elementery/Secondery (0-12)	College (1-4or 5+)		e kind of wo DO NOT u		1)		9	0			
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should be and Mental marked o	T _o												MO 007
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Pages 1 and the ment of Hacant: If item uny or other		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☑ Other (Specify	Removal from State	Plece of Disp cemetery, cr SUPPE	emetory or o	ther ple	,	0	1/17 998			ity or Tow Mary	m, State y l and
permit. Pages Department of Important: If i any Injury or once.		21. Signeture of Funeral Service Licens	Percentie						AL HOME		Marv	land	20785
		23a. Pert1. Enler the disease, or comp shock, or heart feilure. List only of	lications thei caused the dec								110. 3	1	Approximete interval Between
leath certificate be executed attending physician and for use as the buriel-transit	/Medical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest	b. PRec Due to	or es e conse	f /- equence of):	75p	rational ts (shrd	Prey nes)	mon	11.95		
death c	lan												
tha de	Physician	Pert II. Other eignificant conditions co	ntributing to death but not re	sulting In the	underlying o	ause giv	en in Pert i	i.	23b. Did	tobacco	use cont	ribute to t	the cause of deal
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Physicien: rthis certific iral director,	2	1 Yes 2 No	-	ER/Outpatie			20 NI	ursing Ho	ome 5□Res	idence (B □Other	(Specify)	
Attending P ir death. actor: After ti by the funara	ation:	27. Manner of Deeth 1-□ Neturel 5 □ Pending 2 □ Accident Investigation	28e. Dete of Injury (Month, Day Year)	28b. Time Injury	of A	8c. Injur Wor 1 □	yet k? Yes 2□	No	28d. Describe	how Injur	y occurre	d	
P St P	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ HornIcide determined	28e. Plece of Injury - At I building, etc. (Spec	nome, ferm, s ify)	treet, fector	y, office				(Street en own, Stete		r or Rural i	Route Number,
the Hospital hin 24 hours the Funeral hpletely filled	edicai	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	reician: To the best of my kn Iner: On the basis of exemin end menner stated.	owledge, dee etion end/or l	th occurred nvestigetion	et the tin , in my o	ne, dete en pinion, dee	d plece, th occur	end due to the red et the time,	ceuse(s) , dete end	end mani I plece, en	ner as ste nd due to t	ted. he ceuse(s)
within To th	Me	29b. Signature and title of certifier	10		290	. Licens	e number			29d. Dat	e signed	(Month, D	ay, Year)
M)	M			0	331	.23		1	-13-	58	
		30. Neme end eddress of person who co				1 .	1		1 00	670			
1/		Dr. Jonathan Low			e Fre	deri	ck, M	laryl	Land 20	678			
St	ate	31. Dete filed (Month, Dey, Year)	32. Registrads Sign	12									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, best) 2. Data of Daath Month FON 50 AV ATRICK 10 4a. Facility Name (If not institution, give street and numbar) 4b, City, Town, or Location of Daath 4c. County of Death P.G. COUNTY HEARTLAND OF HYATTSVILLE HYATTSVILLE If Undar 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) MAY 4,1957 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foraign 1X M 2□ F GERMANY Yrs. 40 577-78-8189 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No WASHINGTON DC 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 401 D ST N.E.#1 20002 USA 12. Was Decedent Ever In U,S. Armed Forces? 1≦ Yes 2 □ No If Yes, Give Yaar or Datas: Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Americen Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married BLACK 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorcad 15. Decadent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) UNEMPOLYED N/A 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LEON BEARD MARY CHAPMAN 19a. Informant's Nama/Relationship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4657 DALLAS PLACE #201 TEMPLE HILLS MD 20748 PAMELA L. BEARD /WIFE 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 1-13-98 ALEXANDRIA VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOME 2617 PENN. AVE S.E. WASHINGTON DC 20020 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onsat and Death Immediate Causa (Final disease or condition resulting In death) Due to (or as a consequence of) NINGI Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to complation of ceuse of deeth? 24a. Was an autopsy performed? 20 No 1 Yes 2 No 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

physician s the burial

attending for usa as

page 2 should be de

certificate has

this funeral

After

death.

To the Hospital or Attendi within 24 hours after death To the Funeral Director: A complately filled in by the f

director,

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Be Completed

Certification: To

Medical

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital or Attending Physician: **Physician**

/Medical

Examiner

Funeral

Director

28a-f show

5

items 23a

should be filed within 72 hours after on Mental Hygiena. Therked other than "natural", or ite

permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If Item 27 Ia merked other eny fujury or other traumatic event once.

Baltimore, Maryland 21215-0020

Examiner must be notified at

Director

Funeral

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Completed

Be

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Physician/Medical

Part II. Other significant	conditiona contributing to death	but not rasulting in tha	underlying causa given in Part

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

28a. Date of Injury 5 Pending Investigation 6 Could not be determined

28b. Tima of

28c. Injury at Work?

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end manner as stated.

29e. Certifier

1 X Naturel
2 Accident

3 Suicide

4 Homicide

ledical Examiner: On the basis of examination end/or Investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29b. Signature

29c. License number who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

31. Data filed (Month, Day, Year) State Registrar

HOWDAVPI 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 9

					Certifica	ale Oi	Death		Reg. No.	- Ua	
Physician	Decedent's Ne	eme (First, Middle, Las	st)					2. Dete of De Month	eeth Dey	Year 3.	Time of Deeth
/Medical	ANN							Januar	4	98 6	:35 A.M
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Funeral	5. Social Security		ex 7. A	ge (In yrs. lest	Month	der 1 Year os Deys		Hrs. 8. Date of Bi	rth sy, Year)	9. Birthplace Country)	(Stete or Foreign
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Dacadant's Nama (First, Middla, Las	t)	Certifica	te of D		2. Data of Dea	Reg. No.	3. Tima of Dea
Physici	an	AUDREY D. BLAC					Month	Day Y	'aar
/Medic		4a. Facility Nama (If not institution, give			4b	. City, Town, or Loc	Januar y		
Examin	er	MALCOLM GROW ME				Camp Spr			George's
Francis		5. Social Security Number 6. Se		. last birthday) If Und					2
Funeral Director	Ē		□M 2□F 95	Yrs. Months	Days	Hours Min.	8. Data of Birth (Month, Day Aug. 1.	, Year) 5, 1902 W	Birthplaca (Stata or For Country) Vashington,
ms 23a or 28a-f show	J.	10a. Stata 10b. County		ity, Town or Location					10d. Insida City Lir
88	ect	Maryland Prince Ge	orge's	Forest	ville ip Coda			10g. Citizan of Wh	X
0 0	ă	7420 Marlboro Pik		101. 2		747			
ne 23a	era	11. Marital Status	12. Was Decedant Evar In	IS 13 Was Dan		• • • •	cify Vac or No.		Amarican Indian,
or its	by Funeral Director	1 Navar Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yas 2X No If Yas, Giva Yaar or Datas:	if Yas, sp		panic Origin? (Spe , Maxican, Puarto F Specify:	lican, atc.)	Black, Specify:	White, etc. Black
netur	Completed	15. Decedant's Ed (Specify only highest grad Elementery/Secondary (0-12)	fa completed) College (1-4or 5+)		ork dona du usa ratired)	uring most of workin	ng	16b. Kind of Bush	
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o ott	Be	17. Fathar's Nama (First, Middla, Last)			1	18. Mother's Nama			
and Mental Hygie s marked other ti umstic event, ti	2	Robert Delaney					ie Simo		1.5. 10. 10. 54.
ls m		19a. Informant's Name/Ralationship (T	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	19b. Mailing Addras					
Haelt Im 27 Iher t		Myrna L. White		4221 Be		Rd., N.E			
H Ma		20a. Mathod of Disposition 1 XBurial 2 ☐ Cramation 3 ☐i		cematary, crematory or	othar place,)	Data	20c. Location - Ci	ty of Iown, Stata
tant:		4 □ Donation 5 □ Othar (Specify	Li	ncoln Memor			9/98	Suitlar	nd, MD
Department of Heelth and Mantal Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Mones.		21. Signitura of Panaral Sarvice Licens	to on A		nd Addrass Benn:	of Facility St		Funeral Hash. D.O	
		23a. Part1. Antar tha disaasa, or comp shock or haart feilura. List only of	lications that caused the dea	A Laboratoria		_			Approximata Interval Batwee Onsat and Deat
hysician /Medical xaminer	Jer	Immediata Causa (Final disassa or condition resulting in deeth)	a. Hygen tun Dua to	or as a consequence of	erry (cula Di	island		Several yr
ng physician and es the buriel-transit	Aedicai Examiner	Sequantially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disease or Injury that initiated evants rasulting in death) Last	c	or as a consequence of					
ed by the ettending deteched for use es	Physician/M		d						
0 %	yslc	Part II. Other significant conditions co	ntributing to death but not ra	suiting In tha undarlying	causa giver	n In Part I.	23b. Did to	obacco use contr	ibute to the cause of de
igned by be detec	by Ph						101	/ee 2□No 3	☐ Probably 4 Ø Unk
s been s 2 should	Completed						24a. Was a perfor	an autopsy med?	24b. Wara autopsy findle avaliable prior to complation of cause of daath?
ped	Con						1 🗆 Y	as 2 No	1 ☐ Yas 2 ☐ No
is certificate he director, pege	Be	25. Was casa rafarred to medical axaminar?				26. Placa of Death	(Check only or	na)	
h. After this certific funeral director,	2	1 Yas 2 No 27. Manner of Death 1 Natural 5 Panding	Hospital: 1 Inpatiant 2 28a. Data of Injury (Month, Day Year)		28c. Injury a Work?	at 2		ance 6 Other	
ofter deeth. Director: After	Icat	2 Accident invastigation 3 Suicide 6 Could not be	One Place of Inlune 111	M M		as 2 No	Of Location (C	Stead and Alimber	or Pural Pouta Alumbas
s efter deets 4 Director: od in by the	Certification:	4 Homicida datarmined	28a. Placa of Injury - At I building, atc. (Spec	ify)	ту, опісв	2	City or Tow	n, State)	or Rural Routa Number,
2 00 00	edical		sician: To the best of my kn ner: On the basis of examin and menner stated.						
24 hours Funers letely fills		AND DESCRIPTION OF THE PROPERTY OF THE PROPERT		25	e. Licansa	number		29d. Data signed (Month Day Year)
within 24 hours effer deeth. To the Funersi Director: After thi completely filled in by the funeral	Me	29b. Signatura and Iitla of certifiar	11 -	1					
within 24 hours To the Funers completely fills	Me	Signatura and little of certifier	Pola		Do	7348		JAN.	
within 24 hours e To the Funeral D completely filled	Me	30. Nama and address of person who	ompleted cause of death (Ite						6, 1998

DHMH 16 Ray 6/95

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ched for use as the burial-transit permit. Pages 1, 2, 3 should nospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 6876

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writim 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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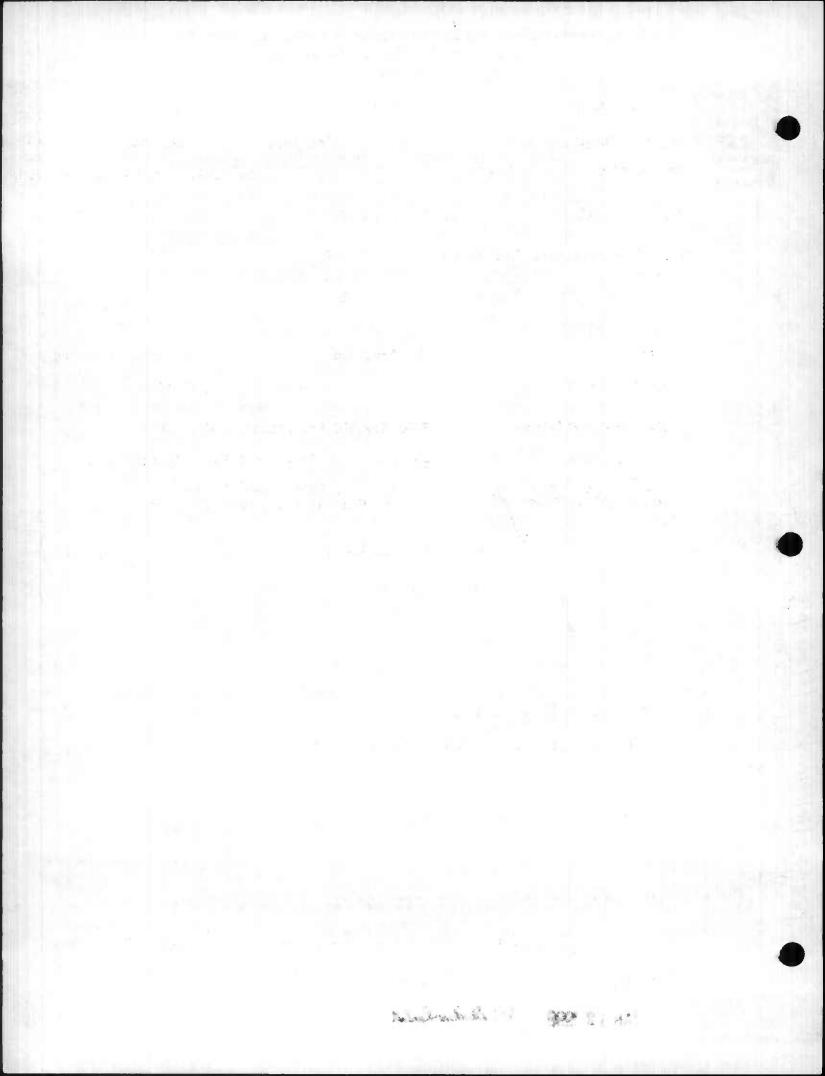
	1 - STATE REGISTRAR	STATE OF MARYLAN	ID / DEPARTM			MENTAL HYGIE		
1	1. DECEDENT'S NAME (First, Middle, Last) CHEOR CHANA	BURKE				2. DATE OF DEATH MONTH		3. TIME OF DEATH S 1 20 A M
y	577-22-6931	□ M 2 💢 F 87	7 YRS. MON		IF UNDER 24 HRS. HOURS MIN.		1910	Sirthplace (State or Foreign Country) Montgamery, MD
TOR	9a. FACILITY NAME (If not institution, give street Pineview Nursing & RESIDENCE OF DECEDENT			Clin	ton,	EATH	9c. COUNTY	G DEATH
DIRECTOR	10e. STATE 10b. COUNTY DC		10c. CITY, TO	WAS	shington	, pile	422	10d. INSIDE CITY LIMITS? YES 2 \(\text{\text{\text{NO}}}\) NO
FUNERAL	100. STREET AND NUMBER 2001 15th Street 1	NW # 508		101	20009			N OF WHAT COUNTRY?
BY FUN		. WAS DECEDENT EVER IN U. FORCES? 1 YES		If yes, sp	ENDENT OF HISPAN	NIC ORIGIN? (Specify on, Puerto Ricen, stc.)	Yes or No 14	. RACE — American Indian, Black, White, stc. Specify Black
COMPLETED	15. DECEDENT'S EDUCATIK (Specify only highest grade com Elementary/Secondary (0-12)	ON 16 opleted) ollege (1-4 or 5+)	6a. DECEDENT'S USU (Give kind of work life. Do NOT use ret Housekee	done during mo ired.)	ON st of working		usiness/indus	TRY
COM	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maid	en Surname)	
BE (Charles M. McPhers 199. INFORMANT'S NAME (Type/Print)	on				Nelson Mc		
2	Arthur James Stew					Aoute Number, City or 1		ide)
- 19	20e METHOD OF DISPOSITION XX Buriel 2 Cremetion 3 Removal 4 Abonation 5 Other (Specify)	from State 20b. PI	LACEAND DATE OF DI ery, crematory or other p SUFFECTION	olaca)			location - cm	y or Town, State , Maryland
1	21. SIGNATURE OF FUNERAL SERVICE LICENS ROSINGLES			22. NAME AI	ND ADDRESS OF FA	CILITY W	ashingt	con, DC 20020 Jr. Avenue SE
CERTIFICATION	23. PART I. Eyer the diseases, or com ahock, or heart failure. List iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentisliy list conditions, if eny, leeding to immediata ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF):	Sec	ent for	glass		Approximata interval Between Onset and Death
PHYSICIAN: MEDICAL		CO MAC OUTE TO CAUSE OF	CAZ DEATH YES	□ NO [PERF	AN AUTOPSY FORMED?	24b, WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIA		OSPITAL: Inpatient 2 ER/Outpati	PLACE OF DEATH (C	HER:				
BY PHYS	27. MANNER OF OEATH 1 Netural 5 Pending Investigation	26s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. IN.	DURY AT DRK? YES 2 NO	6 Other (Specify) 28d. DESCRIBE HDV	W INJURY OCCU	RED
	3 Suicide 6 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY — building, atc. (Specify,	At home, farm, atree	it, factory, offic		281. LOCATION (Stre City or Town, Sta		Rural Route Number,
COMPLETED	one) MEDICAL EXAMINER: O	N: To the best of my knowled On the besis of examination a						cause(a) and manner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	noles,	-200		D /	15595	294. DATE 1	10/198
10	HYOK LITE M	D 1660	Locust	Gle	N DR.	Mada	cestile	=180 20121
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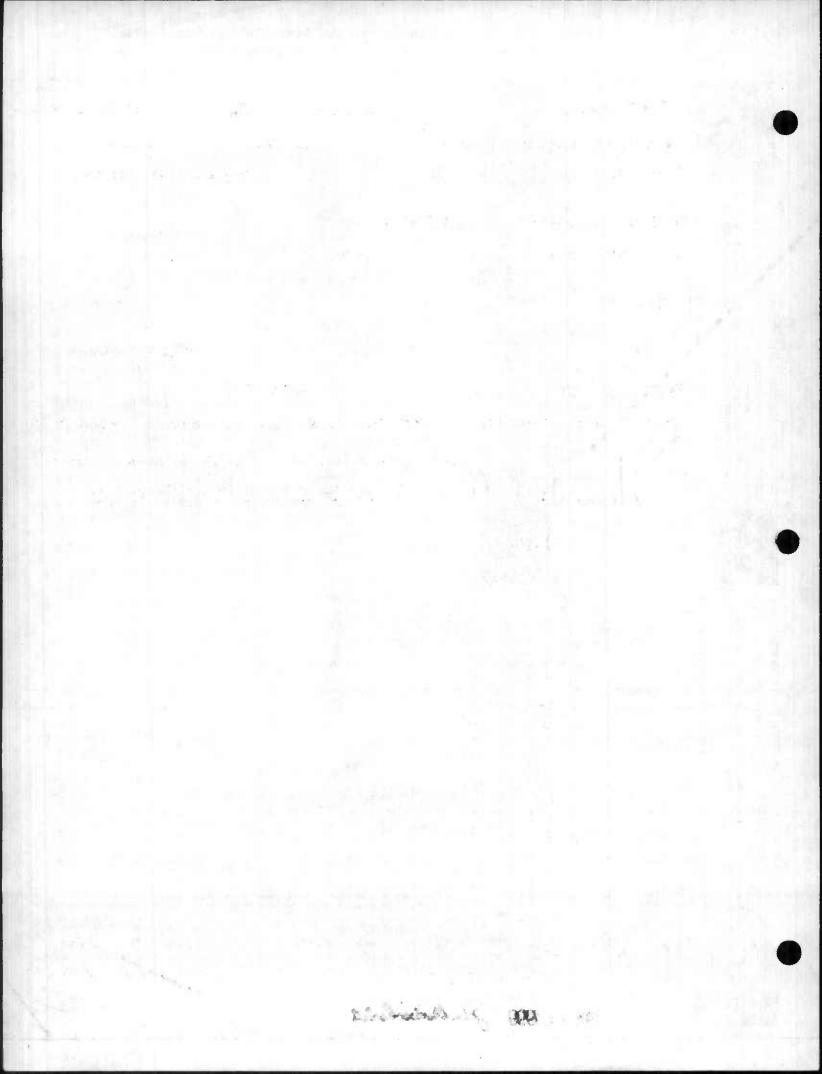
State of Maryland / Department of Health and Mental Hygiene 98 0225

					Certifica	ate o	f Death		Reg. No.) U	2234
Dhusi		1. Decedent's Name (First, Middle, La	ast)	7-6			12.7	2. Date of De Month		Year	3. Time of Death
Physic /Med		ADELAIDE	G.		BRA	GG		JAN.		998	4:03 PM
Exam		4a. Facility Name (If not institution, gir					4b. City, Town, or I	Location of Deal	h 4c. County	of Death	
		Suburban Hospita			- VIII	J. 4 W.	Bethesda	-	Montgo		
Funera Directo			Sex 7. Age 1□ M 2FVF 96	e (In yrs. les	Yrs. Month	der 1 Yearns Dey		8. Date of Bi (Month, D Sept. 1	th ey, Year) 4, 1901	9. Birthp Coun Washi	lace (State or Foreign try) Lngton, D.C
Maryland 4 show led at	tor	10a. State 10b. County N/A N/A			fown or Location	D.C.				11	0d. Inside City Limits
with the Marylan as or 28s-f show	i Director	10e. Street and Number 2702 Wisconsin A	ve. N.W. Ar	ot. 80	i	Zip Code			10g. Citizen of USA	What Coun	try?
020 urs after death with the Marylai al', or items 23e or 28e-f show Examiner must be notified at	by Funeral	11. Maritel Status 1 Never Married 2 Married 3 🛱 Widowed 4 Divorcad	12. Was Decedent B Armed Forces? 1 Yes 2 N	Ever in U,S.	13. Was De If Yes, s		f Hispanic Origin? (Suban, Mexican, Puert	pecify Yes or No o Rican, etc.)	o- 14. Rac Bia	ce - Americ ck, White, o	etc.
Maryland 21215-0020 42 should be filed within 72 hours at 1h and Merital Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Exam		15. Decedent's E	Year or Dates:		16a. Decedent's U	suai Occ	upation	data =	16b. Kind of B		
d 2121 filled within 1 Hygiene, ther than "pm, the Med	Completed	(Specify only highest grant Secondary (0-12)	College (1-4or 5		Publicat		ne during most of wor ired)	King	America	n Pod	1 Cross
d d 2		17. Father's Name (First, Middle, Last	")		Tubitcat	TOILS	18. Mother's Nan	ne (First Middle			Cross
d be sering	To Be	Basil Friel	,						William	-	
ary na mary mary	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Meiling Addre	ess (Stre	et end Number or Ru				Code)
		Louise Schindel/I	Viece			bold	Dr. Beth			7	
Baltimore, semit. Pages i ar Separtment of Hea mportant: if New 2 my Injury or other		1 Donetion 5 □ Other (Special		cam	etery, cremetory of	or other p	n Cemeter			•	
Balt Permit. Departr Importa		21. Signatura Funeral Service Lice	ngoo L.		Georg	е P.	dress of Facility Kalas Ful	neral H	ome		
Of		23af Part 1. Enter the disease, of com- shook, or heart failure. List only	polication Mar caused	the death.	6160 Do not enter the m	Oxon	Hill Rd.	Oxon H	ill, Md.	2074	Approximete
Physician		whock, or heart failure. List only	11					,	,	1	Interval Between Onset and Death
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Examine		resulting in death)		Due to (or as	s e consequence	of):					15 days
0 E B E	ine		b)ehr	1 dratio	3				10	1: days
x 68760, erificate be executed ling physician and e.e so the bunel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or a	s a consequence o	of):					
68760 filicate be 1 physician	edicai	thet initiated events resulting in death) Last	c	Due to (or as	a consequenca o	of):					
X 6	12		d								
O. Bo.	cian										
P.O. Box hat the death cer ad by the ettendin	Physician/	Part II. Other significant conditions of			ng in the underfyin	g cause	given in Part I.				the cause of death?
cords, P.O. Box 68760, requires that the death certificate be executed signed by the ettending physician an hould be deteched for use as the buriel-th	by	Sevene	Dannent	10				1	Yes 2 No	3 Prot	pably 4 Unknown
3 1 8	Completed	old Cerel	oro Vasu	Sen	ace	ide	nt.	24a. Was perf	an autopsy ormed?	CON	ere autopsy findings eileble prior to mpietion of cause death?
of Vital Rec Physician: The law in this certificate has by an director, page 2 st	P O							10	Yes 2 No	1	Yes 2□ No
/ita	Be	25. Wes case referred to medical examiner?					28. Plece of Dee	th (Check only	one)	1	
Of Vita Of Vita Physician: this certific	J.	1 ☐ Yes 2 No	Hospital: 1 Inpatier			DOA			idenca 6 DOth		0
ion ding th. Afte	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Dete of Injur (Month, Dey	Year) 28	Bb. Time of Injury M	28c. In W	juryat /ork? □Yes 2□No	28d. Describe	how injury occur	rred	
四百 5 青高点	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	e 28e. Placa of Inju building, etc	Iry - At home . (Specify)	e, farm, street, fact	tory, offic	a	28f. Location City or To	(Street end Numl wn, Stete)	ber or Rura	l Route Number,
To the Hospital within 24 hours 8 To the Funeral Completely filled	edicai (29a. Certifier 1 Certifying Pt (Check only one)	yelcian: To the best o niner: On the basis of and manner ste	examination	dge, death occurre and/or investigeti	ed at the ion, in my	time, date and place opinion, death occu	, and due to the	cause(s) and made and place,	anner as st and due to	ated. the cause(s)
To the Hos within 24 h Completely	Me	29b. Signeture and title of cartifier				29c. Lice	nse number		29d. Date signe		Dey, Year)
		1 dums	-ul)				37891		JAN	09	1998
(5)		30. Name and address of person who ARADVANSH	completed cause of de	21 U	Ba) (Type, Print)	svir	nal In #	409 R	vcknW	emp	20852
St	ate	31. Date filed (Month, Dey, Year)	32 Registra	r's Signature							



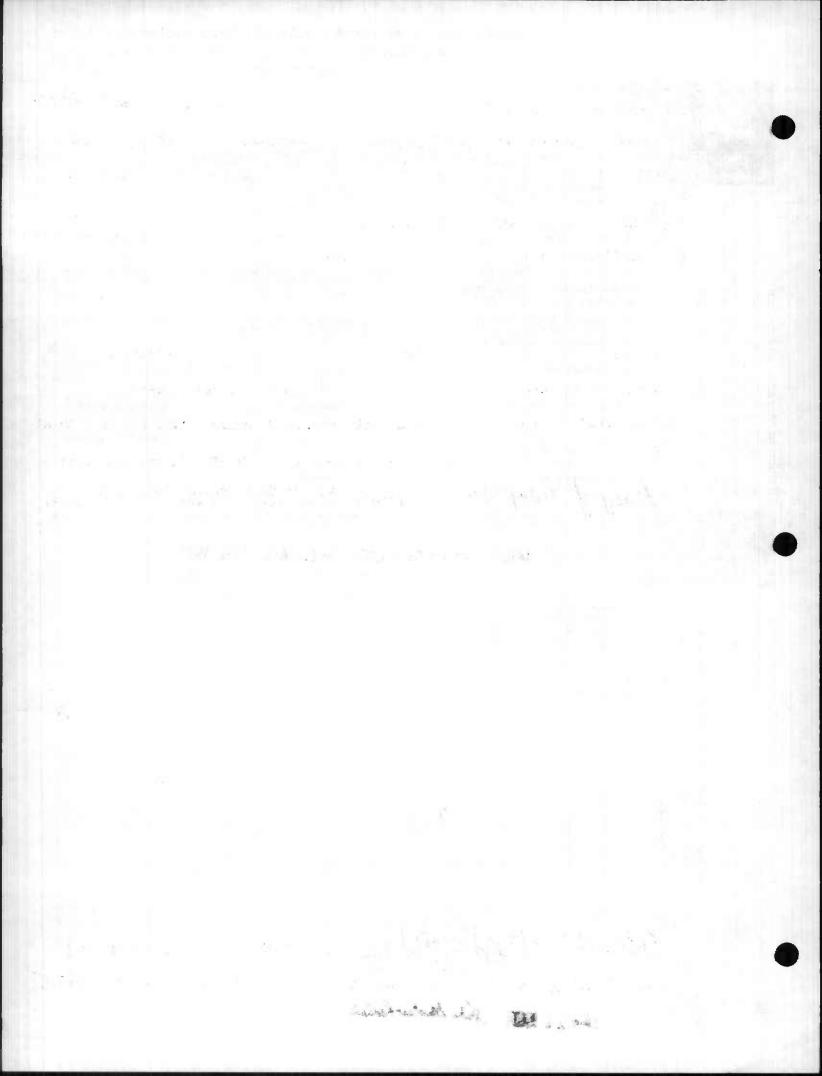
State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Nama (First, Min	ddle, Last)			- 1			Death	2. Dete of D			V	3. Time of Dec
Physician		CATHERI						BAS	60	Month	De 13		Yeer 1998	6:45
/Medica Examine	-	4a. Fecility Neme (If not institu	tion, giva s	traat and number)			2773	4b. City, Town, o			. County		4.73
LAGITITIC									T-1- D	1				
unaral		Washington A 5. Social Security Number	6. Sex			. lest birthday)	If Un	dar 1 Year	Takoma P				gomer	
uneral irector		579-32-9523 Usual Residence of Decedent		M 2⊠ F		92 Yrs.	Mont	hs Days	Hours Min		9, Year	05	Scot1	eca (State or Fo y) and
show	_	10a. Stata 10b. Cour	nty			ity, Town or Lo							10	d. Insida City Li
Page 1	S P		gomer	у	S	ilver S	-				,			1 X Yes 2 □
2 2 2	5	10e. Street end Number						Zip Code			10g. Ci	tizan of V	Vhat Countr	ry?
23a	ā	918 Langley D						20901				S.A.		
4 4	by Funeral Director	11. Marital Status 1 Nevar Married 2 M 3 X Widowed 4 Divorce	erried	 Wes Decedant Armed Forces' Yes 2 M If Yes, Give Year or Dates: 	?			scedent of I specify Cub s 2 No	Hispenic Origin? (ean, Mexican, Pue Specify:	Specify Yes or North Rican, atc.)	10-		e - America ok, Whita, et Whit	tc.
Medical Medical	Completed	15. Deced (Specify only hig Elementary/Secondery (0-12		etion completed) College (1-4or	5.\\	16a. Deced (Give	ent's U kind of OO NO	sual Occup work done Tuse retire	petion during most of w	orking	16b. k	Kind of Bu	usiness/Indu	ustry
ther than	ē	12	,	College (1-40r	D+)	Seam	str	ess			Se1	f Em	ploye	d
othe /ent,	Pe C	17. Fethar's Nama (First, Midd	la, Last)						18. Mother's No	eme (First, Middl				
D S S	0	Patrick McCar	nn						Helen	Donach	ie			
s marked o	-	19e. Informent's Name/Reletion		e, Print)		19b. Mailin	g Addr	ess (Street	end Number or F			or Town.	Stete, Zip C	Code)
27 is		Sandra J. Motz	- Gr	eat Nied	e				nell Place					
othe		20e. Method of Disposition		1120		Plece of Dispos cematary, crem				Date			City or Tow	
5 6	1	1 X Burlel 2 ☐ Crematio		moval from Stete						1 /17 /00				
rtan Unio	-	4 □ Donation 5 □ Other 21. Signature of Funeral Service		01) FC	ort Line				1/17/98	Br	entw	ood, l	Marylan
important: if item 27 is any injury or other tra once.		> /- enny	J. S.	Fort	1	Fr	anc	is Ga	ess of Fecility Asch's So Imore Ave	ons Fune	ral	Home vill	, P.A	20781
sician		23a. Pert1. Entar tha disease, shock, or heert feilure. L	or complic ist only one	ations thet ceuse ceuse on each I	d tha dea ine.	ith. Do not ante	ar tha m	node of dyi	ng, such es cardi	ac or raspiretory	errest,		1	Approximete intervel Betwee Onset end Deer
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ian e		Sequentially list conditions, if eny, leeding to immedieta ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events	1	Cere	by	o [rap	cci	lar	GCC	clei	1.)-		1	2.97
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pege 2	5									1	Yes 2	No	10	Yes 2 10
rector, per		25. Wes cese referred to media	cel						26 Place of D	esth (Check only				100 22110
		examiner? 1 ☐ Yes 2 ☑ No	-	spitel:		leno	•□	Ott	nor			- 5-		
	- -	27. Manner of Deeth 1 ☑Neturel 5 ☐ Pend	ding stigation	28e. Dete of Inju (Month, De		28b. Tima of Injury	3 M	28c. Inju	4 Li Nursing	Home 5 Ras				
	5	3 ☐ Suicida 6 ☐ Coul	d not ba	28e. Plece of Inj	unc - At h	ome form etro				28f Location	(Street or	nd Numbe	er or Rural I	Route Number,
		4 ☐ Homicide Gete	mined	building, et	c. (Speci	(y)				City or To	own, Stet	9)		
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by the funeral		29a. Certifier 1 Certify (Check only one) 1 Certify 2 Medica	ing Physic ai Examine	end menner st	otou.									
by the funeral	2000	Check only 2 Medica	ni Examine	end menner st	0100.		1	29c. Licens	se number		29d. Da	te signed	(Month, De	ey, Year)
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by the funeral	House	one) 2 Medici	ier L	end menner st		m 23a) (Type, F		D196	109		JAM	1, 1.	3- 19	998



State of Maryland / Department of Health and Mental Hygiene 8

					Certificate	of	Death		Я	leg. No.	UL	200
Dhyois	ion	1. Decedent's Name (First, Middle, La	ist)				100	2	2. Date of Dee Month	th Day	Year	3. Time of Death
Physic /Med		ROBERT	BRADY						JANUAR	Y 11 19	798	05:37 PM
Exami		4a. Facility Name (If not institution, given				-	_		ation of Death	4c. County		,
		PRINCE GEORG			101			/ERL>			EE	itoratis
Funeral Director			Sex 7. Age (In yrs		hday) If Under 1 Months	Days	If Under Hours	Min.	B. Date of Birth (Month, Dey uly 4,	Year) 1936		place (State or Foreigntry) 12nd
pue te		10a. State 10b. County	10c. C	ity, Town	or Location						T	10d. Inside City Limits
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ath with 23a or	rai Dir	4618 Burlington R	T		207	781				U.S.A.		
be filed within 72 hours efter death with the Maryland la! Pyglena. d other than "natural", or items 23a or 28a-f show event, the Madical Examinat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	J,S.	13. Was Decede If Yes, specif 1 Yes 2	fy Cuba	an, Mexicar	n, Puerto Ri	ify Yes or No- can, etc.)	Ble	ck, White,	
72 hc	ted	15. Decedent's E (Specify only highest gra	ducation		Decedent's Usual (Give kind of work			t of working		16b. Kind of B	usiness/ir	dustry
2 should be filed within end Mental Hygiena. s marked other than a	Completed	Elamantary/Secondary (0-12) Unknown	College (1-4or 5+)		iiie. DO NOT use	retire	d)	t or working		Const	ruoti	ion
be filed ntal Hygin of other		17. Father's Name (First, Middla, Last)	01	VIICI		18 Mothe	ar's Name /	First Middle	Maiden Suman		LOII
	o Be	John Edward	Bradv				Laui	11400	ebecca	Simps	0.5	
d 2 should th end Mer 7 Is marks traumatic	2	19a. Informant's Name/Relationship (19h	Malling Addrass ((Street						n Code)
		Carolyn Brady -										and 20781
ges 1 and it of Haelth If Itam 27 or other tr		20a. Method of Disposition		Place of	Disposition (Name	e of		au, n		20c. Location		
		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			r, crematory or oth sincoln (1/				Maryland
permit. Peg Depertment Important: I sny injury o		21. Signature of Funeral Service Lice	nompson		22. Name and Francis	Gas	sch's	Sons	Funera	1 Home	, P.A	١.
		23a. Part1. Enter thy disease, or com- shock, or hear failure. List only		th Don	4739 Ball	ltir	nore A	Avenue	e, Hyat	tsvill	e, MI	20781 Approximate
Physician /Medical Examiner		Immediata Cause (Final disease or condition rasulting in death)	a ARTERIOSCUE	POTIC								Interval Between Onsat and Death
Si &	liner		b	or as a c	orisequence or).							
the death certificate be asscuted y the ettending physician and sched for use as the burial-trensit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury	Due to	or as a c	onsequence of):							
ifficete be axe g physician a as the burial-	edicai	Cause (Disease or Injury that Initiated events resulting in death) Last	C. Due to (or as a co	onsequence of):							
ath certific etending p for use as	≥	•	d									
eath ce ettendi	cla	Post II. Other plantileast conditions of	and the state of a state to a section	tata t	Ab				OOL DISE	Oleven a company	-0.45 0- 0-	
that the dended by the end datached	by Physician/	Part II. Other significant conditions of	outhorting to death but not re	suiting in	the undariying cat	usa giv	en in Part I			es 2 No		o the cause of death
sicien: The law requires thet cartificate has been signed b irector, page 2 should be dete	Completed b								24a. Was a perform		a\ cc	era autopsy findings vailable prior to emplation of cause death?
Tha la ate ha	Son								1 U Y	es 20 No	1	□Yes 2□No
ician: The	Be (25. Was case raferred to medical examinar?					26. Place	of Death (Check only or	10)		
- × × v	Tol	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	ER/Out	patiant 3 DOA	Oth	iar: 4□ Nu	rsing Homa	a 5 □ Resida	ance 6 Oth	ar (Speci	fy)
Attanding Ph or death. octor: After th by the funerel		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Year)	28b. Ti	me of 28 jury M	c. Injur Wor	yat k? Yes 2⊡		d. Describe h	ow Injury occur	red	
5 # # E	Certification:	3 Suicide 6 Could not b determined		noma, fan	m, street, factory,	office		28	f. Location (Si City or Town		er or Run	al Route Number,
Hospit 24 hour Funera tely fills	edical C	29a. Certifier 1 Certifying Ph (Check only one) 1 Madical Example 1	yelcian: To the best of my kn niner: On the basis of examin end manner stated	owledge, ation and	death occurred at /or investigation, in	t the tir	ne, date an pinion, dea	d place, an	d due to the c	ause(s) and ma ate and place,	anner as s and due t	stated. o the causa(s)
To the To the comple	Me	29b. Signature and title of certifier	ntofall,	An	1 PME	Licens	e number	54		9d. Date signe		
(19)		30. Name and eddress of person who MARIO F. GOLVE	completed cause of death (156	m 23a) (T	Type, Print) HOSELTAL	- (PRIVE	, CH	every,	, MAK	PLANI	1998
Sta Regist		31. Data filad (Month, Dey, Yeer)	32. Registrar's Sign	ature	or Revolate							
		JAN 19	1300									



State of Maryland / Dep

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artment	of Healt	h and Me	ental Hy	giene	UZ	20	

MOSES CLAUDE BEATTY Certificate of Death Reg. No. 2. Data of Daath 1. Decedent's Name (First, Middla, Last) 3. Time of Death Month **Physician** 9, Moses Claude Beatty, Jr. JAN. 1998 1753 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES If Undar 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Days Hours Min. 1♥M 2□ F 48 Yrs. May 26,1949 Anderson, SC Director 578-64-2562 Usual Rasidance of Decedan permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Merylend Department of Heelth end Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Evantinet must be notified at energy. 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ¥ Yas 2 □ No Directo MD Prince George's Riverdale 10f. Zip Code 10g. Citizan of Whet Country? 10e. Street and Number 4814 Tuckerman Street 20737 IISA Funeral 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amaricen Indian 11. Marital Status Black, Whita, atc. 1 X Yas 2 ☐ No If Yas, Giva Yaer or Detas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ♥ No Spacify: Specify: Black by 3 Widowad 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highast grada complated) Elementary/Secondery (0-12) Collaga (1-4or 5+) Disabled 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be Moses C. Beatty Jannie Ellington 19a. Informant's Nama/Ralationship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Jannie Beatty/Mother 4814 Tuckerman Street Riverdale, MD 20737 20b. Place of Disposition (Nama of cematery, cramatory or othar place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 17/98 1 Denial 2 Cramation 3 Removal from Stata 4 Donation 5 Othar (Specify) MD National Memorial Park Laurel, MD 21. Signaty of Funeral Service M 22. Nama and Address of Facility Tyrone J. Young Funeral Services
719 Kennedy Street, NW Wash., DC
not antar tha moda of dying, such es cardiac or raspiratory arras Approximata Intarval Between Onset end Death **Physician** /Medical Immediata Cause (Finel disaasa or condition rasulting in daath) cenhosi of the liver Examiner Examiner Chronic alcohol abrus physician end the buriel-trensit The law requires that the death certificate be executed Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated evants resulting in daeth) Last Due to (or es a consequance of): Division of Vital Records. P.O. Box 68760. Physician/Medicai Dua to (or as a consaquance of): 98 attanding | 980 for signed by the a 23b. Did tobacco usa contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 □ Unknown by 24b. Wara autopsy findings availabla prior to complation of cause of daath? should I 24a. Was an autopsy performed? Completed 1 Tas 2 □ No 1 XYas 2 No Be 26. Place of Death (Check only ona)

After this certificate has funeral director, pega 2: or Attending Physician: To After this Certification: death. Director: A • Funeral Dire aftar Hospital

25. Was casa rafarred to madicel examiner? Yes 2□ No 27. Mennar of Death

1 Neturel

2 Accident

3 Sulcida

29a. Cartifian

edicai

4 Homicide

(Check only one)

5 Panding invastigation

6 Could not be

28a. Dete of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☑ Pr/Outpetient 3 ☐ DOA 28b. Tima of Injury

28c. Injury et Work? 1 Yas 2 No 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Spacify)

28d. Describe how injury occurred

Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State) 1 Certifying Physicien: To tha best of my knowledge, daath occurred et tha time, dete end place, and dua to tha causa(s) end mannar as stated.

29b. Signatura and titla of certifier Nonald & Wright MI

O.C.M.E

Medical Exeminar: On the besis of axemination and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and mennar statad.

29c. Licansa number

29d. Data signed (Month, Day, Year) JAN. 10, 1998

30. Name end addrass of person who complated cause of death (Itam 23a) (Type, Print)

Hospital:

DOUMD G WRIGHT 31. Data filad (Month, Day, Year)

JAN 1 5 1998

111 Penn Street, Baltimore, Maryland 21201

State Registrar

mpletely

To the To the

32. Ragistrar's Signatura Jaka Bludson Royles

BARNES

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month

9, 1998

11:20 PM

January

STREET, MOUNT RAINIER MD20712

Physician /Medical Examiner

MINNIE

Funeral Director

the Maryland 28a-f ahow the Medical Examiner must be notified at death with 6 items 23a 72 hours after 6 "natural", Hygiana. permit. Peges 1 end 2 should be flied with Department of Health and Mental Hygians important: if item 27 is merked other than any injury or other traumetic event, the April 2006.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

attending physician end for use es the burial-transit The law requires that the death certificate be asscuted P.O. Box 68760, signed by t Records, paga 2 s certificate Division of Vital s efter death.
I Director: After this of in by the funeral di

To the Hospital or Attending Physician: "
within 24 hours effer death.

to the Funeral Director: Affar this certifical ampletaly filled in by the funeral director; p

4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Washington Adventist Hospital Takoma Park Montgomery 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) 1□M 2□F Deys Hours Yrs. 579-58-3731 55 May 20, 1942 South Carolina Usual Residence of Decedent 10a, Stete 10b. County 10c. City. Town or Locetion 10d. Inside City Limits NO Yes 2□No Director D.C. N/A Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1246 Florida Ave. NE 20002 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give^X Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black 1 Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 2 yrs. Secretary US Patent Office 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Alonzo Hines Bessie Mae Blackley 19a. informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) James Barnes - Husband 1246 Florida Ave. N E Washington DC 20002 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 Other (Specify) Lincoln Memorial Cemetery 1-16 Suitland, MD 22. Name end Address of Fecility
Marshall's Funeral Home, Inc. 21. Signature of Funerel Service Licenses 4217 9th Street N W Washington DC 20011 11 nter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest pod, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest ertension Physician/Medicai enal disease Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 2000 1 Yes 2 ZNo 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? elow The 1 Yes 2 Ro 1 Yes 2 00 Be 25. Was case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Phpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Maturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29e. Certifier 1 Certifying Phyeiclen: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medicel Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end manner steted. 29d. Date signed (Month, Dey, Yeer)

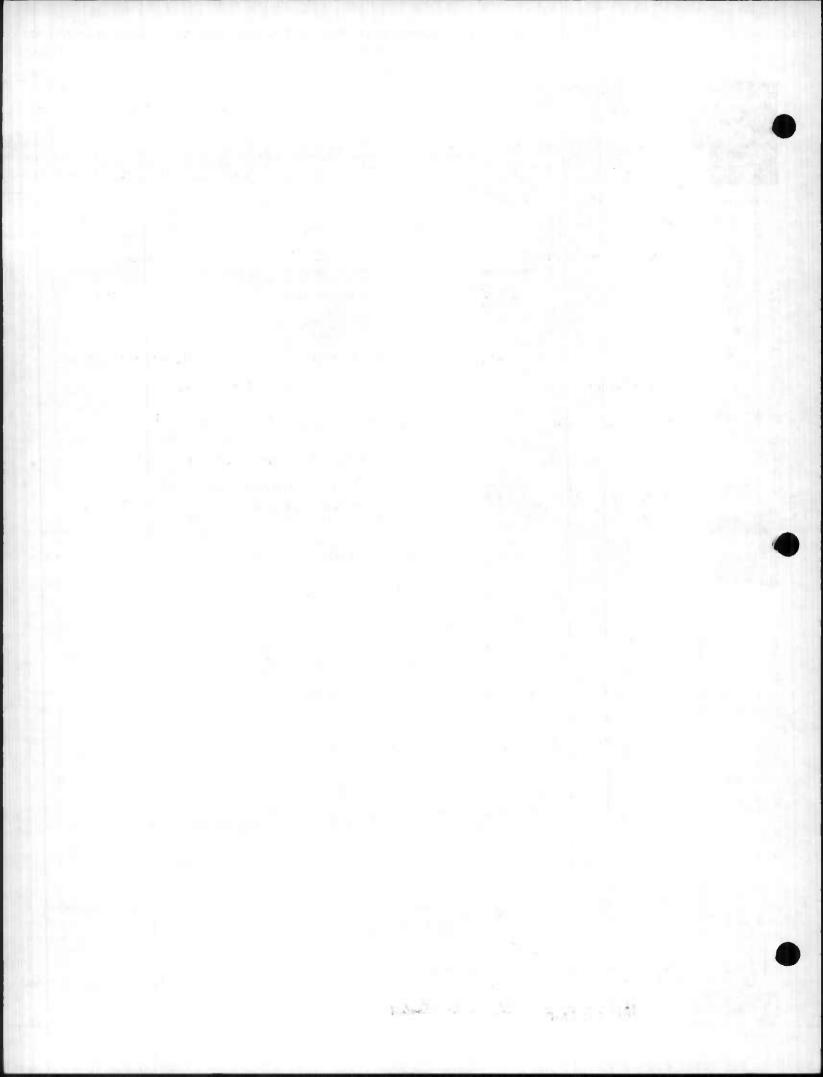
JAN, 10 1998 29b. Signature and title of certifier 29c. License number D19609

State Registrar 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

3503 PERRY

RAMAN K. TULI

31. Dete filed (Month, Day, Pear)
JAN 15 1998



State of Maryland / Department of Health and Mental Hygiene 8 0225

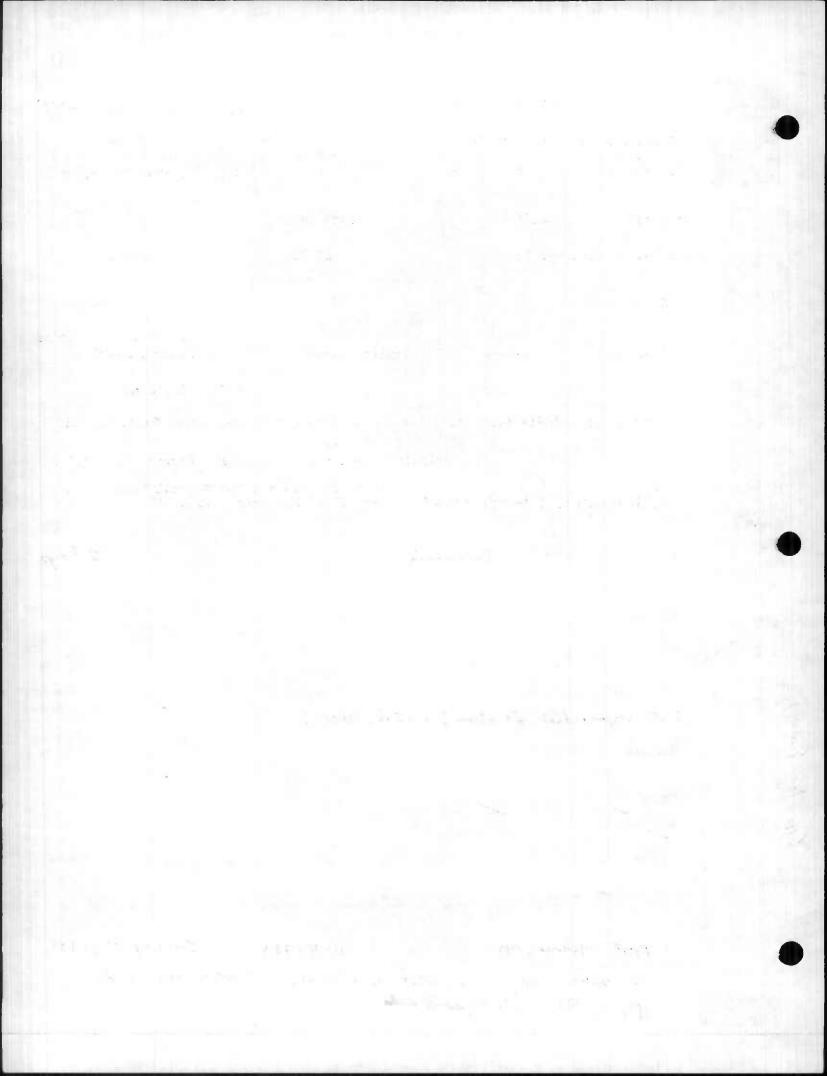
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	ysician Iedical	Decedent's Name (First, Middle, La Mary	Elizabeth	Cummin	gs						y 1 ² 2 ^y , 1	9 98 1	3. Time of Death 10:00 am
	aminer	4a Facility Name (If not Institution, git Parkside Assiste	re street and number) ad Living	Facilit	y			4b. City, Town Catons	svil				County
Fund Direct		094- 07-5264	Sex 7. Ag 1 □ M 2/5XF	e (In yrs. last bi 82	rthday)_ Yrs.	If Unde Months	Days		4 Hrs. Min.	8. Data of Bir	th 1/3(7°,4°) 1915	9. Birth	place (State or Foreign
2 .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow		ation	_						10d. Inside City Limits
e Maryla	ctor		ore County			tons	svil.	le					1 ☐ Yas 2 ☒ No
death with the Maryland me 23s or 28s-f show	al Dire	303 North Rolling	g Road			10f. Zi	p Code	21228			10g. Citizen of US		intry?
or its	parimet must be notified by Funeral Director	11. Maritai Status 1 Never Married 2 Married **Midowed 4 Divorced	12. Was Decedant Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Datas:			/as Dece Yas, spe		Hispanic Originan, Maxicen, I Specify:	n? (Spec Puerto P	cify Yas or No Ricen, etc.)		ce - Ameri ick, Whita fy: Whi	
5-00	ted le	15. Decedent's E	ducetion	16a	. Decede	ent's Usu	al Occu	petion during most o	al wartin		16b. Kind of E	Business/I	ndustry
d 21215-0020 filed within 72 hours of Hygiene. ther than "natural", or	completed by	(Specify only highest gr	College (1-4or :	5+)	real	ONOT	ise retire	ed)	Ur WORKIII	9	real	estal	te
Maryland 21215-002 d 2 should be flied within 72 hours in and Mentel Hygiene. 7 is marked other than "natural",	To Be C	17. Father's Nama (First, Middla, Last James Albert								(First, Middle, Terhu	Maiden Suma ne	me)	
y, Maryla and 2 should satth and Men	er traume	19a. Informant's Name/Relationship Ms. Jane Cumming		aughter	81	.87 9	Stow				er, City or Town hio 442		ip Code)
Baltimore, Mary	ry or oth	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		20b. Place of cemeter Metro	of Dispos ery, crem Cre	sition (Na latory or emato	me of other pla Dry	ice)	13	JAN98	20c. Location Catons		
Baltimor permit. Pages Depertment of H Important: If its	any injury once.	21. Signatury of Funeral Service Lice	nsee	M0053		Name a	Sla	ess of Facility			P.A. land 21	042	
Physic /Medi Exami	ical ner	23a Part1. Enter the disease, or conshock, or heer feilura. List of the constant of the consta	plications that caused one cause on each li		RUC	TIL	EP					1	Approximate Interval Between Onset and Death Several Hears
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	be deta	Brandogenic Co	ercinoma							112	Tes 2∐No	3 □ Pro	obably 4 Unknown
0 0 0	C D	<u> </u>									en eutopsy ormed?	a	Vere autopsy findings vallabla prior to ompletion of ceuse f deeth?
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of Vital Rec Physician: The law this certificate has b	director, page	25. Was cese referred to medical examiner?	Hospital					har.		(Check only			
6 E		1 Yes 2 No	Hospital: 1 Inpatie				UA		-		dence 6 O		eity)
DIVISION C atter death. I Director: After t	by the funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		y Year)	Time of Injury	М	28c. Inju Wo 1	iryat ork?]Yes 2 □ No		8d. Describe	how Injury occu	irred	
Division tal or Attending rs after death.	led in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not to determined	20e. Place of Inj	ury - At home, fa c. (Specify)	arm, stre	et, facto	ry, office		2	8f. Location (City or To		ber or Ru	ral Routa Number,
To the Hospital or within 24 hours after To the Funeral Direction	Medical Cert		nysicien: To the best miner: On tha basis o and manner st	f axamination ar									
within 2	W Som	29b. Signature and title of certifier				29	c. Licen	sa number			29d. Date sign	ed (Month	n, Day, Year)
	y	NR 72				7	18.	317			JAV,	12 1	998
1	<i>y</i>	30. Name and address of person who											
		BERNARD P. FARRE	ELLMD III	DSS LITT	LEF	PATIL	KENS	PKWY	160	Lum By	A, mb	210	44
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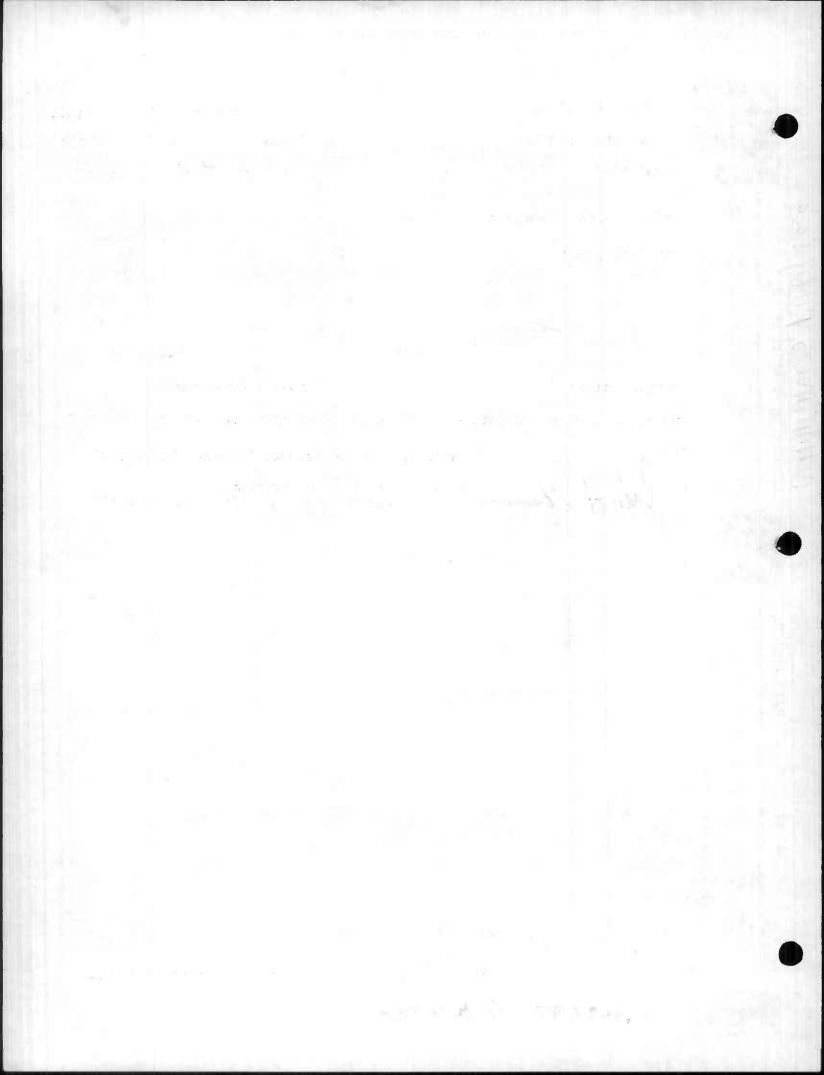
State of Maryland / Department of Health and Mental Hygiene

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uneral irector		5. Sociel Security No.	0005	Sex 7 1 □ M 2 X TXF	Age (In yrs.	lest birthday) Yrs.	If Under Months	Days	If Under 24 Hr Hours Mir		23,1	906	9. Birthpled Country Penns	e (Stete or Fo ylvani
M III		Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or Lo	cation						10d	. Inside City Li
if sh	tor	Maryland		Cecil			N	orth	East					1 XYes 2
or 28)irec	10e. Street end Nun	nber				10f. Zip	Code			10g. Cit	izen of V	Vhet Country	?
23a	raic	Lot No. 4	, Westov	er Plaza				2	1901			U.	S.A.	
important: I fam 27 is marked other than "natural; or flems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified all once.	by Funeral Director	11. Maritei Status 1 ☐ Never Marrie 3 ☐ Widowed		12. Was Deced Armed Forc 1 Tyes 2 If Yes, Give Year or Date	es? ŒXNo				lispanic Origin? (an, Mexicen, Pue Specify:	Specify Yes or to to Rican, etc.)	10-		e - Americen k, White, etc	
atura icel E	ted	/0	15. Decedent's E	ducetion		16e. Deced	ient's Usua	al Occup	petion		16b. K	ind of Bu	isiness/Indus	
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7 Is n traur		19a. Informant's Na Harriett		, ,	uchter				end Number or F					
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any ir		Man	M.c=	faller.	20		Lee A	. Pa	tterson					
		23a. Pert1. Enter the shock, or heer	e disease, or con	plications that cau	sed the dee	th. Do not ente	erthe mod	VIII le of dyir	e, Mary	Land 2] ac or respiretory	.903-(errest,	J188	A	pproximete
shoo ysician		snock, or heer	cremure. List only	one cause on eac	ai IINO.								In	tervel Betwee nset end Dea
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the	edic	resulting in deeth) L	est		Due to (d	or as e consequ	uence of):						1	
C S	3			d										
O1 0	= 1													
O1 0	siciar	Pert II. Other signification	cent conditione	contributing to deal	h but not res	ulting In the un	nderlyina o	euse aiv	en in Pert I.	23b. DI	d tobacco	use con	tribute to th	ne cause of d
O1 0	Physician	Pert II. Other signific									tobacco	/		
O1 0	by Physician	Pert II. Other significants										/	3 Probat	oly 4 □ Uni
O1 0	eted by Physician									1[24e, We		No	3 Probat	eutopsy findi
s been signed by the attending 2 should be deteched for use t	mpleted by Physiciar									1[24e, We	Yes 2	No	3 Probat	eutopsy findi
s been signed by the attending 2 should be deteched for use t	Completed by Physician/	Acute m Anemia	yocarde							1[24e. We	Yes 2 es en eutop formed?	No	3 Probab 24b. Were eveile comp of dec	letion of ceus
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ne Funeral Diractor: After this certificate hes been signed by the attending pletely filled in by the funeral director, page 2 should be deteched for use e	edical Certification: To Be	Aremia 25. Wes case referrexaminer? 1 Yes 2 Manner of Deeth 1 Naturel 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signeture end to	ed to medical So Pending Investigetic Could not be determined To Certifying Pi	Hospital: 1 Tip 28e. Dete of (Month, n) 28e. Plece of building 1 yelclen: To the basiend manner.	atient 2 Injury Dey Year) Injury - At h, etc. (Special cost of my knot so of examine	ER/Outpetien 28b. Time of Injury ome, ferm, stre	t 3 DC	OA Otherse. Injury Word 1	26. Plece of Doner: 4 Nursing yet k? Yes 2 No	24e. We pe 1 [eeth (Check only Home 5] Re 28d. Describ 28f. Location City or 7	Yes 2 Ye	PNo PSY No 6 □Otherry occurred Number of Number of Number of Number of Place, €	24b. Were eveile comp of dec 1 1 Y	eutopsy finding ble prior to eletion of ceuseth? Yes 2 No Route Number, ed. e ceuse(s)
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DHMH 16 Rev 6/95



11. Marital Stetus	Dey Yeer y 16,1998 1:05AM 4c. County of Deeth PRINCE GEORGE'S 9. Birthplece (State or Foreign Country) Alabama 10d. Inside City Limits 120 Yas 2 No 10g. Citizen of Whet Country? USA 14. Race - American Indien, Bleck, Whita, etc. Specify: White 16b. Kind of Business/Industry Restaurant Malden Sumeme)
4e. Fecility Name (II not institution, give street and number) DOCTORS HOSPITAL 5. Social Security Number 420-14-0369 1	4c. County of Deeth PRINCE GEORGE'S 9. Birthplece (State or Foreign Country) Alabama 10d. Inside City Limits 1) Yas 2 No 10g. Citizen of Whet Country? USA 14. Race - American Indien, Bleck, Whita, etc. Specify: White 16b. Kind of Business/Industry Restaurant Malden Sumeme)
DOCTORS HOSPITAL S. Social Security Number 6. Sex 420-14-0369 1 m 2 m 7. Age (in yrs. lest birthday) 1 under 1 year 1 under 24 Hrs. 8. Dete of Birth 420-14-0369 1 m 2 m 7. Age (in yrs. lest birthday) 1 under 1 year 1 under 24 Hrs. 8. Dete of Birth 420-14-0369 1 m 420	PRINCE GEORGE'S 9. Birthplece (State or Foreign Country) Alabama 10d. Inside City Limits 120 Yas 2 100 10g. Citizen of Whet Country? USA 14. Race - American Indien, Bleck, Whita, etc. Specify: White 16b. Kind of Business/Industry Restaurant Malden Sumeme)
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Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Prince George's Hyattsville 10e. Street end Number 5802 40th Avenue 11. Marital Stetus 10 Hyattsville 11. Marital Stetus 10 Hyattsville 11. Marital Stetus 10 Hyattsville 11. Marital Stetus 10 Hyattsville 11. Marital Stetus 10 Hyattsville 12. Wes Decedent Ever in U.S. Armed Forces? 10 Hyattsville 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerio Rican, etc.) 15. Decadent's Education (Give kind of work done during most of working life. Do Not usa ratified) 15. Decadent's Education (Give kind of work done during most of working life. Do Not usa ratified) 17. Fether's Name (First, Middle, Last) George Madison 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number or Rurel	10d. Inside City Limits 120 Yas 2 No 10g. Citizen of Whet Country? USA 14. Race - American Indien, Bleck, Whita, etc. Specify: White 16b. Kind of Business/Industry Restaurant Malden Sumeme)
10a. State 10b. County 10c. City, Town or Location 10f. Zip Code 10b. Street end Number 10f. Zip Code 20782 10b. Street end Number 10f. Zip Code 20782 10b. Street end Number 10f. Zip Code 20782 10b. Meind Stetus 10b. Street end Number 10f. Zip Code 20782 10b. Meind Stetus 10b. Street end Number 10f. Zip Code 20782 10b. Meind Stetus 10b. Street end Number or North Specify Cuban, Mexican, Puerto Rican, etc.) 10b. Meind Mexican, Puerto Rican, etc.) 10b. Meind Mexican, Puerto Rican, etc.) 10b. Meind Mexican, Puerto Rican, etc.) 10b. Meind Mexican, Puerto Rican, etc.) 10b. Meind Mexican, Puerto Rican, etc.) 10b. Meind Mexican, Puerto Rican, etc.) 10b. Meind Mexican, Puerto Rican, etc.) 10b. Meind Mexican, Puerto Rican, etc.) 10b. Meind Mexican, Puerto Rican, etc.) 10b. Mexican, etc.) 10b. Mexican, etc.) 10b. Mexican, et	1)D Yas 2 No 10g. Citizen of Whet Country? USA 14. Race - American Indien, Bleck, Whita, etc. Specify: White 16b. Kind of Business/Industry Restaurant Malden Sumeme)
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Second and a property Second and a property Second and a property	USA 14. Race - American Indien, Bleck, Whita, etc. Specify: White 16b. Kind of Business/Industry Restaurant Malden Sumeme)
3 Widowed 4 Divorcad If Yes, Give Year or Detes: 1 Yes No Specify:	Specify: White 16b. Kind of Business/Industry Restaurant Malden Summeme)
Secondary Seco	Specify: White 16b. Kind of Business/Industry Restaurant Malden Summeme)
15. Decadent's Education (Specify only highast grede completed) Etamantary/Sacondary (0-12) 8 Collaga (1-4or 5+) 8 To. Fether's Name (First, Middle, Last) George Madison 19a. Informent's Neme/Relationship (Type, Print) Shirley M. Randles (Daughter) 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removel from State 4 Doration 5 Other (Specify) 21. Signature of Fueral Service Licansee MO0173 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa railred) Waitress 18. Mother's Name (First, Middle, Last) 19b. Meiling Address (Street end Number or Rure/ Route Number) 7620 Chapel Point Road Port To cemetery, cremetory or other piece) Trinity Memorial Gardens 1-13-98 22. Name end Address of Fecility J. H. Eberwein Mortuary 4433 White Pls La White Pls	Restaurant Malden Sumeme)
17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rure/ Route Number of Shirley M. Randles (Daughter) 7620 Chapel Point Road Port To comelery, cremetory or other piece) Date 12	Restaurant Malden Sumeme)
17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) George Madison Girlie Frost Male	Malden Sumeme)
17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) George Madison Girlie Frost Male	
19a. Informent's Neme/Relationship (Type, Print) Shirley M. Randles (Daughter) 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removel from State 4 Dorytton 5 Other (Specify) 21. Signature of Fu eral Service Licansee M00173 19b. Meiling Address (Street end Number or Rurel Route Number of 7620 Chapel Point Road Port To Cemetery, cremetory or other piece) Trinity Memorial Gardens 1-13-98 22. Name end Address of Fecility J.H. Eberwein Mortuary 4433 White Pls La White Pls	Madison
Shirley M. Randles (Daughter) 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removel from State 4 DorAtion 5 Other (Specify) 21. Signature of Fueral Service Licansee M00173 Address of Fecility J. H. Eberwein Mortuary 4433 White Pls La White Pi	
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21. Signature of Fuerral Service Licansee MO0173 22. Name end Address of Fecility J.H. Eberwein Mortuary 4433 White Pls La White Pls	Waldorf, MD
4433 White Pls La White Pl	
	M 2060E
	Onset end Deeth
Immediate Cause (Finel diseasa or condition rasulting in death) e. SBY S1S	~10 dg
Due to (or as a consequanca of):	
Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying	
Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events Due to (or es e consequence of): Due to (or es e consequence of):	
Ceuse (Disease or Injury thet initiated events resulting in death) Lest Due to (or es e consequenca of):	
d	obacco use contribute to the cause of death?
	es 2 No 3 Probably 4 Unknown
24a. Was a perior	med? eveileble prior to completion of cause of deeth?
104	es 210 No 1 Yes 2 No
25. Wes casa raferred to medical examinar? 26. Pleca of Death (Check only or	16)
1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Reside	
5 1 Natural 5 □ Pending (Month, Dey Year) Injury Work?	ow injury occurred
2 Accident investigation M 1 Yes 2 No 3 Sulcide 6 Could not be 289 Piace of Injury. At home farm street fectors office.	treet end Number or Rural Route Number,
28e. Piace of Injury - At home, farm, street, fectory, office building, etc. (Specify)	n, Stete)
29a. Certifier (Check only (Ch	ause(s) end menner es statad. ate and placa, end due to the causa(s)
	9d. Dete signed (Month, Day, Year)
30. Name end eddress of person who completed cause of daath (Item 23e) (Type, Print)	1/16/98
S.M. NAYAR MD 3717-38 AVE COTTAGE CITY, N	1/16/98
State 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature strar 1AN 2 0 1998	1/16/98 ND 20722



R

Disease Type or Drint in Plack Indeithic Ink. Assure All Conics Are Legibio

3-0229-033	riease Type of Fillit in Diack indensite in	A. Assule All C	obics Are regio	10.
lc	State of Maryland / Department of	Health and Men	ital Hygiene	022
ICHARD WAYNE CLEGG	Certificate of	f Death	Reg. No.	022
4. Decedents Name /	First Middle Loss	0.1	Date of Dooth	2 Tie

Physician
/Medical
Examiner

RICHARD WAYNE

CLEGG

Month January

3. Tima of Death 15, 1998 0715a

62

Funeral

4e Fecility Nama (If not institution, give street end number) Potomac Pallet Inc. 4820 Frolich Lane 6 Say 7. Aga (In yrs. last birthday) XXM 2 F Yrs.

4b. City, Town, or Location of Deeth Hvattsville

Min.

8. Data of Birth (Month, Day, Year)

4c. County of Death Prince Georges

Director

28a-f show

Directo

Funeral

þ

Completed

7 is marked other than "naturel", or items 23a or 28a-f short treumstic event, the Modical Examiner must be nothled at

parmit. Pages 1 end 2 should be filed within 72 hours efter or Department of Health end Mental Hygiena. Important: if Item 27 ie marked other than "naturel", or item

or other

Hygiena.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

the Meryland

death

10a Stata 10h County

Usual Rasidance of Decedant

214-82-0009

10c. City, Town or Location

DEC. 12, 1965 MARYLAND 10d. Insida City Limits

9. Birthplaca (Stata or Foraign

MARYLAND

CHARLES

PORT TOBACCO

Months

1 ☐ Yas 2 X No 10g. Citizen of What Country?

10e. Street and Number

8280 WOODDY ROAD

32

20677 Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Ricen, atc.)

UNITED STATES

11 Maritai Status

1 Nevar Marriad 2 Married 3 Widowed 4 Divorced

12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 2 100 If Yes, Giva Yaar or Datas:

1 Yes XXNo Spacify:

If Under 1 Year | If Undar 24 Hrs.

Hours

Days

WHITE

14. Race - Amarican Indian, Black, Whita, atc.

POMFRET, MD

Approximate Interval Batwaen Onsat and Death

15. Decedant's Education (Specify only highest grade complated)

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired)

16b. Kind of Businass/Industry

Elamentary/Secondery (0-12)

SUPERINTENDANT

10f. Zip Coda

CONSTRUCTION

17. Father's Name (First, Middla, Last)

HARRY E. CLEGG, SR. 19a. Informant's Name/Relationship (Type, Print) BARBARA J. ELLISON

19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)

PAM CLEGG - WIFE

20a. Mathod of Disposition

1 M Burlal 2 Cramation 3 Ramoval from Stete 4 Dona 5 Othar (Specify)

8280 WOODDY ROAD, PORT TOBACCO, MARYLAND 20677 20b. Place of Disposition (Nema of camatary, cramatory or other place) Data 20c. Location - City or Town, Stata

G. BROHAWN MARK G.

JOSEPH'S CEMETERY, JAN. 19, 1998, THE HUNTT FUNERAL HOME, INC.

P.O.BOX 156, WALDORF, MARYLAND

18. Mothar's Nama (First, Middle, Maiden Sumama)

Physician /Medical Examiner

> 98 usa

signed by the a

has page 2

After this funeral

Attending

i or Attending after death. Director: Aft

24 hours a Hospital

within 2 To the

Aq

Completed

Be

P

Certification:

Medical

Immediate Cause (Finel disaasa or condition rasulting in death) Examiner physician end the buriel-trans Physician/Medical

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of):

Due to (or es e consequence of):

Sequantially list conditions, if any, laading to Immadiata causa. Enter Undarlying Causa (Disaasa or injury that initiated avants resulting in death) Last

23b. Did tobac	co use co	ntribute to the	cause of death?
1 🗆 Yes	2 No	3 Probably	4 Unknown

24a. Was an autopsy

24b. Were eutopsy findings eveilable prior to

1 Yas	2□ No

completion of ceuse of death?

					X	Yas	2□ No
26.	Plece	of	Deeth	(Check	only	ona)	

Yes 2 No

25. Wes casa referred to medical axaminer? XIX Yas 2 No 27. Mannar of Death

5 Panding invastigation 6 Could not be determined 28e. Dete of Injury (Month, Day Year) -98 -15 Plece of Injury - At hor building, atc. (Specify)

Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I.

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 0700

At home, farm, street, factory, office

28c. Injury et Work? 1 X Yas 28d. Describe how injury occurred Klids

Other: 4 Nursing Home 5 Residence 6 State (Specify) SCENE

overtured ortosubject 28f. Location (Street and Number or Rural Routa Number City or Town, Stata) Ityattsv.Ke 20 Plattic

29a. Cartifian

1 Natural

Accident 3 Sulcida

4 Homicide

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29c. Licanse number

29b. Signat

O.C.M.E.

January 16, 1998

29d. Date signed (Month, Day, Yeer)

and addrass of person who completed cause of deeth (Item 23a) (Type, Print)

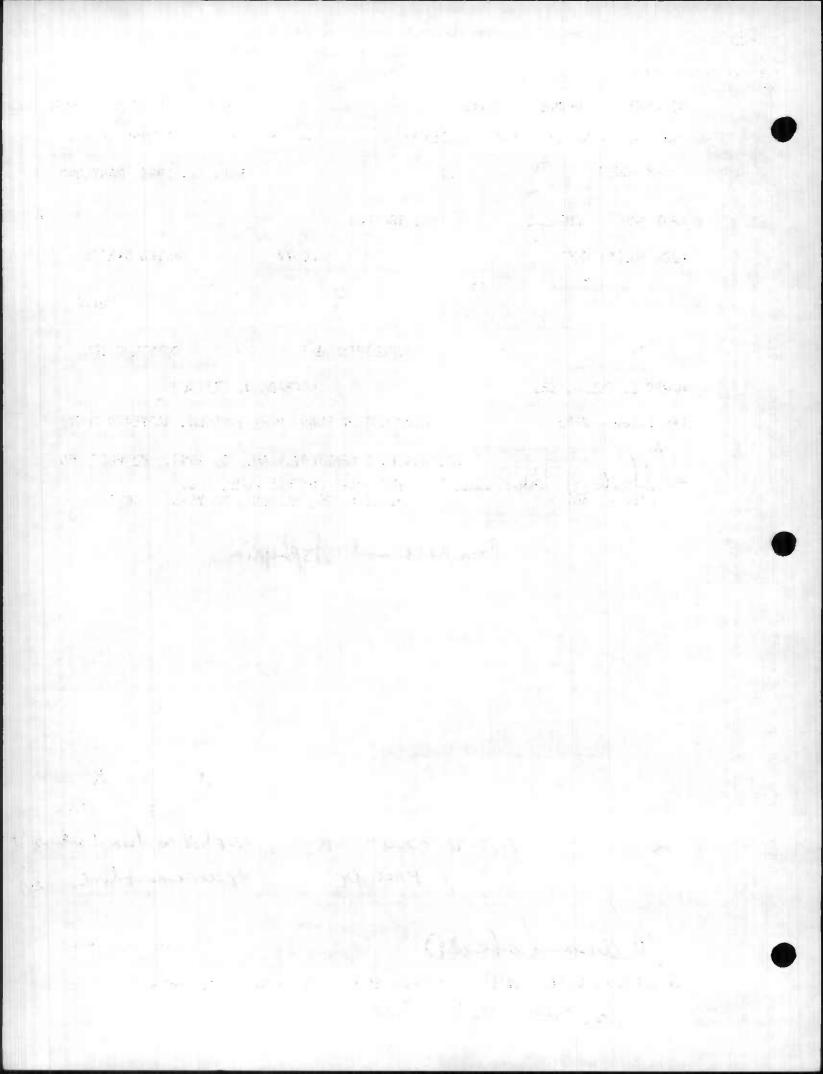
MNO J-LAREN LICKE 31. Data filad (Month, Day, Yaar)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

JAN 2 0 1998

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** MARY ALICE CASTLE JANUARY 12, 1998 9:17AM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner SILVER SPRING MONTGOMERY HOLY CROSS HOSPITAL If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yeer) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** Months Deys 1 M 2 XF Yrs. MAY 4, 1952 WASHINGTON, D.C. Director 45 577-72-5421 the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Moural Examinat mant be notified at MARYLAND MONTGOMERY SILVER SPRING 1 XYes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with UNITED STATES 20910 1110 FIDLER LN. APT. 1016 Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No It Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK by 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE SALES CLERK 12TH 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) 12 should be fill h and Mental H Be MARTHA CRAWLEY HOWARD JONES, SR. 10 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 Is m any injury or other traun page. MICHAEL CASTLE/ HUSBAND 1110 FIDLER LN. APT.1016 SILVER SPRING, MD. 20910 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 🗷 Removel from State MORNING STAR CEMETERY 1/17/98 4 ☐ Donetion 5 ☐ Other (Specify) MONTROSS, VA. 22. Name and Address of Fecility
ALEXANDER S. POPE FUNERAL HOMES 21. Signature of Funeral Service Licensee Juneye M1085 5538 MARLBORO PIKE/FORESTVILLE, MD. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximete tntervel Between Onset end Deeth **Physician** CARCINO MARONS /Medical Immediete Cause (Final diseese or condition resulting in deeth) 6 months Examiner Examiner physician end is the burief-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that introduced to the control of Due to (or es e consequence of): Box 68760 Physician/Medical that initieted events Due to (or as e consequence of) resulting in death) Lest 88 980 P.O. 23b. Did tobacco use contribute to the cause of death? the Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. signed by 1 ☐ Yes 2 No 3 Probably 4 Unknown Division of Vital Records. g 8 24b. Were eutopsy tindings eveileble prior to 24a. Wes en eutopsy Completed peen completion of ceuse of deeth? 1 Yes 2 No 25. Wes cese reterred to medicel examiner?
1 Yes 2 No Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Date of Injury (Month, Dey Year) funeral 27. Menger of Death 28d. Describe how injury occurred 28b Time of 28c. Injury et Work? Certification: s after death.
I Director: After by in by the funer After Naturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours of To the Funeral C Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner stated. 29a. Certifier edical completely (Check only 29d. Date signed (Month, Dey, Year) VENKARAMA 30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) HANOVER PORKNBY 343-1 31. Dete tiled (Month, Day, Year) 32. Registrer's Signeture Registrar

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Daath Month Lenora J. Carter 11 Pm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Glendale, MD. P.

If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year)

Min. (Month, Dey, Year) 10027 Harbor Ave. Prince George Co. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplaca (State or Foreign Country) 1 M 255 Months 03-12-07 523-12-3360 90 Alabama Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Prince George NE Yes 2□ No Glendale MD. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10027 Harbor Ave 20769 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2★100 If Yes, Giva Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Naver Married 2 ☐ Married 1 Yes 2€No Specify: Specify: Black 3€ Vidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry College (1-4or 5+) Elementary/Secondary (0-12) Federal Gov 5+ Psychiatric Social Worker 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Effie Goodloe Jerry James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
100027 Harbor Ave
Glendale, Maryland 20769 Shawne Carter (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cramatory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 X X remation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Northern VA. Crematory1-9-98 Arlington, VA. 22. Name and Address of Facility
Tri-State Funeral Services, Inc
5234 Third St. NW. Wash. DC. 20 Funeral Service Licensee Part 1. Entar tha disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Ceuse (Final disaase or condition resulting in death) weeks Preumonia Due to (or as a consequence of): aspiration Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or as a consequence of): multiple cerebrovascular accidents that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? Diabetes mellitus; atheros lesoti vasular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to serile demantia (multisofe completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ☐Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Items

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Baltimore, Maryland 21215-0020

Box 68760.

P.O.

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Division of Vital

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Medical

25. Was case referred to medical examiner 1 Yes 20 No 27. Manner of Death 1 ElNatural 2 Accident

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29b. Signature and title of certifie

29a. Certifier

4 ☐ Homicide

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Dey Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

29c. Licansa number

022780

12 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

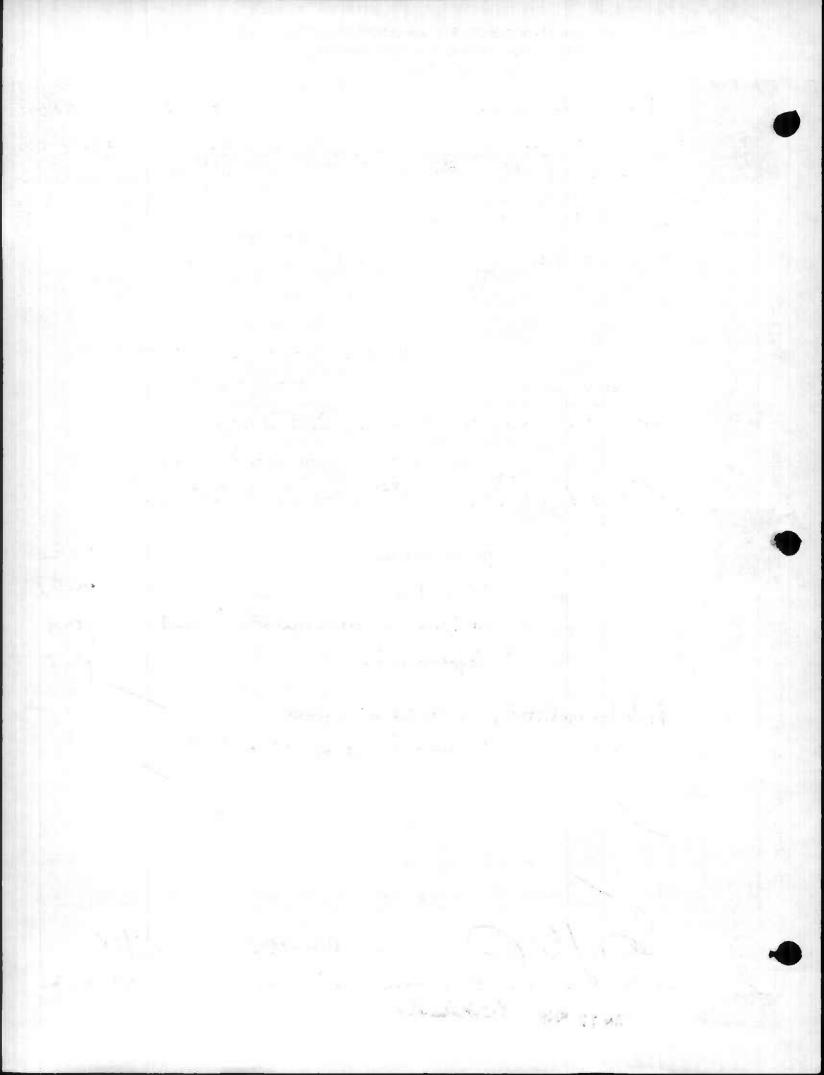
on who completed cause of death (Item 23a) (Type, Print) 7500 Greenway Cr Dr. Greenselt Md 20720

mo 31. Date filed (Month, Day, Year)

IAN 12 1998

32. Pegistrar's Signature

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Vaar **Physician** Month Helen Colbert January 5, 1998 12:48PM /Medical 4a. Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 9003 Mill Court Ft. Washington Prince George's If Under 1 Year If Undar 24 Hrs.

Months Devs Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** 1□M 2□F Yrs. 578-22-5462 79 Director Aug. 27, 1918 Pennsylvania Usual Rasidanca of Dacedant the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2 ☐ No Director Maryland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ŏ 9003 Mill Court Items 23a 20744 United States Funeral 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 11. Maritel Status 14. Race - Amarlcan Indian, permit. Peges 1 end 2 should be filed within 72 hours efter to Department of Health end Mental Hygiene. I moordant: if Ilem 27 is merked other than "naturel", or flee eny Injury or other traumatic event. Biack, White. 1 Navar Married 2 Married African Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: by 3 ☐ Widowad 4 ☐ Divorced American Completed 15. Decedant's Education (Specify only highast grada complatad) 16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) College (1-4or 5+) Cab Driver 11th Self Employed 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Albert Foster Florence Dawson 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Wilbur B. Colbert / Husband 9003 Mill Court, Ft. Washington, MD 20744 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 1/13/98 Clinton, MD 22. Nama end Address of Facility 21. Signature of Funaral Sarvica Licensas Stewart Funeral Home inter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errast, is heart failure. List only one cause on each line. 4001 Benning Rd., N.E. Wash., D.C. 20019 Approximata Interval Between Onset and Death Physician Immediate Causa (Final disaasa or condition rasulting in daeth) /Medical Examiner Examiner physician end s the buriel-transit The law requires that the death certificete be executed Sequantially list conditions, if any, laading to immedieta causa. Entar Undarlying Cause (Disaasa or injury that initiatad evants rasulting in daath) Lest Box 68760, Physician/Medical Dua to (or es e consequence of): 80 ettending p ed by the deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings evellabla prior to complation of causa of death? 24e. Wes an eutopsy performad? Completed peed page 2 s certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital o the Hospital or Attending Physician: " ithin 24 hours efter death." • the Funeral Director: After this certifica 25. Was casa rafarred to medical Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Home 5 A Rasidanca 6 Other (Specify) 1 Yas 2 No Medical Certification: To 1 ☐ Inpaflenf 2 ☐ ER/Outpetiant 3 ☐ DOA After thi 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28b Time of 28c. Injury at Work? 1 K Natural 5 Panding ofter death.

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State of Maryland / Department of Health and Mental Hygiene 8 0 2 2 6

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Vos **Physician** 10.03 AM Adeline Emily Clarke 1998 Jan /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Deeth **Examiner** Doctors Hospital Cheverly If Undar 1 Yaar | If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) 9/2/03 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Hours Devs 1 ☐ M 2 🖾 F Yrs 213-92-6530 94 Director Jamaica Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Nems 23s or 28s-1 show odical Examiner must be notified at 1 Yes 2 No Director MD PG Cheverly 10e. Street and Number 10f. Zin Code 10g. Citizen of Whet Country? 6117 Perry Street Funeral 20785 USA 12. Wes Decedant Evar in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) Reca - Americen Indien, Bleck, Whita, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Yaer or Dates: 1 Navar Marriad 2 Married 1□ Yes 2¹ No Black þ Specify: 3√ Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Buelness/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. 6th Homemaker Private 17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middla, Maiden Sumeme) 8 and Mental James Watson Petgrave Alice Clarke 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) mportant: If item 27 is Marva LaTouche/Daughter 6117 Perry St Cheverly, MD 20785 of Health Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State ò 4 ☐ Donetion 5 ☐ Other (Specify) Harmony Memorial 1/13/98 Landover MD 21. Signeture of Funeral Service Licenses 22. Neme end Address of Fecility Robert G.Mason Funeral Home, 1661 Good Hope Rd SE 23a. Part1. Enter the disaasa, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** Asachanord hemosshage Immediete Ceusa (Final diseese or condition resulting in deeth) /Medical Examiner Dua to (or as e consequence of) Physician/Medical Examiner physician end the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Dua to (or es e consequence of): as ettending p signed by the e P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings eveilebla prior to completion of causa of deeth? 24a. Wes en eutopsy performed? Completed page 2 Lang 1 Tes 2 To 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes cese referred to medicel examiner? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No To After this funerel 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28c. Injury et Work? Certification: 28d. Describe how Injury occurred 5 Pending investigation 1 Yes 2 No death. 2 Accident efter death Director: the 6 Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end manner steted. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) M.D D48213 1 30. Nama and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Milchenville Rd # 220 Bowie MD 20716 N. ASHAI 4000

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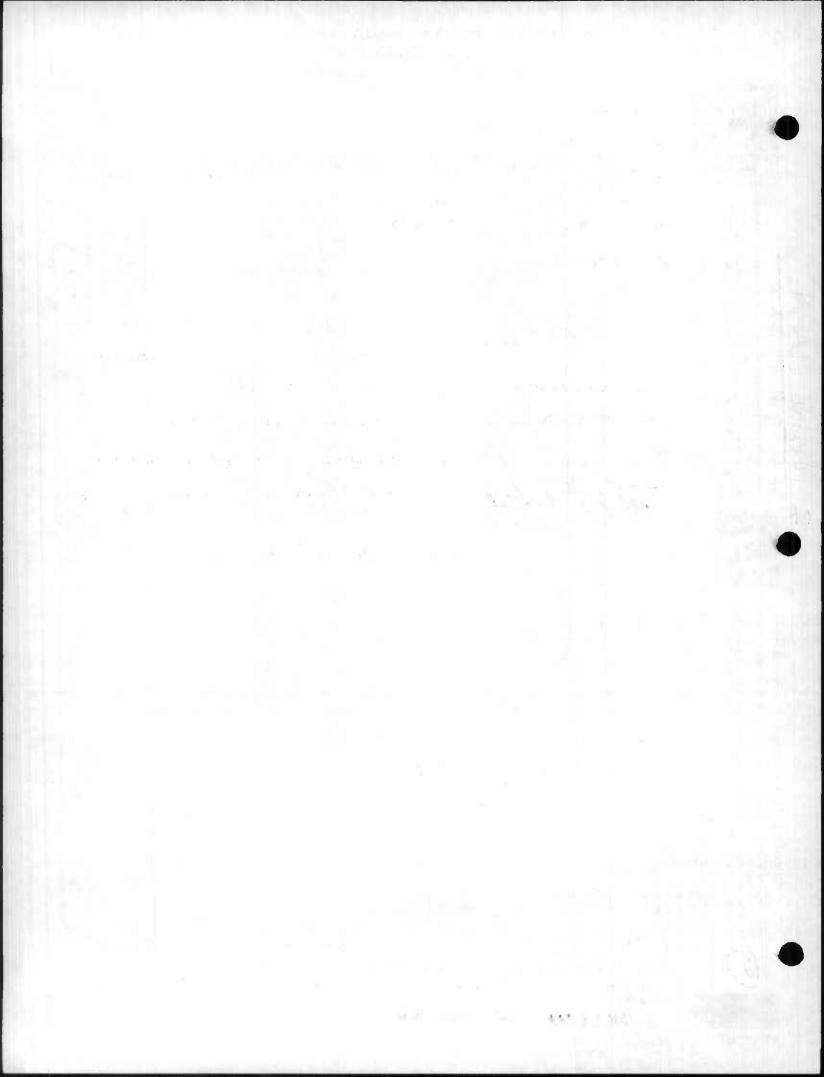
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JAN 14.**1998**

32 Registrar's Signature

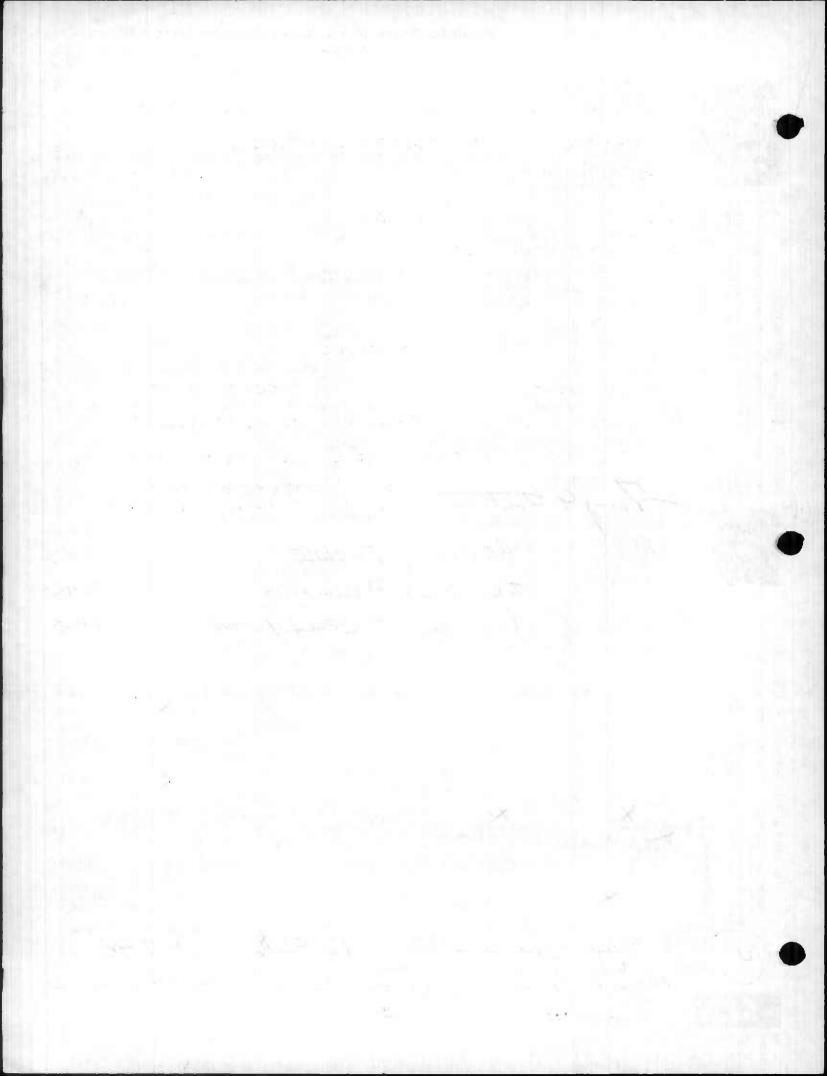
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State of Maryland / Department of Health and Mental Hygiene 9

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Too. State 100. Col. 100.			5. Social Security Number 579-92-2104	6. Sex 7	7. Age (In yrs. lest	birthday)	If Under 1 Ye	ear	If Under 2	4 Hrs.	8. Date of B	irth Pey, Year) 1962	Cou	place (Stete or Foreig intry) H, D.C.				
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23a. Part . Enter the displaye, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, inflerval forest evide. List only one ceuse on each time. 23a. Part . Enter the displaye. Cust only one ceuse on each time. 23a. Part . Enter the displaye. Cust only one ceuse on each time. 25b. Displayer of the death of the death of the ceuse of the part of the death of the ceuse of the part of the death of the ceuse of the part of the death of the ceuse of the c	importa any inju		21. Signeture of Funeral Service L	D. Cust		AU	STIN	ROY	STE	R F			200	11				
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30. Name and address of person who completes asses of deeth (Item 23a) (Type, Print) MEYER R. HEYMUN M.D., CANNOF MDHAR. 22 S.CREWEST. BALTO MD 2 State 31. Date filled (Month, Day, Year) 32. Registrer's Signature			MEYER R. HE	=YMUN W	1.D., CA	(Type, P	Print) FMD/	ba	9. 2.	25	.CREEN	EST. E	34LTO	mD2120/				

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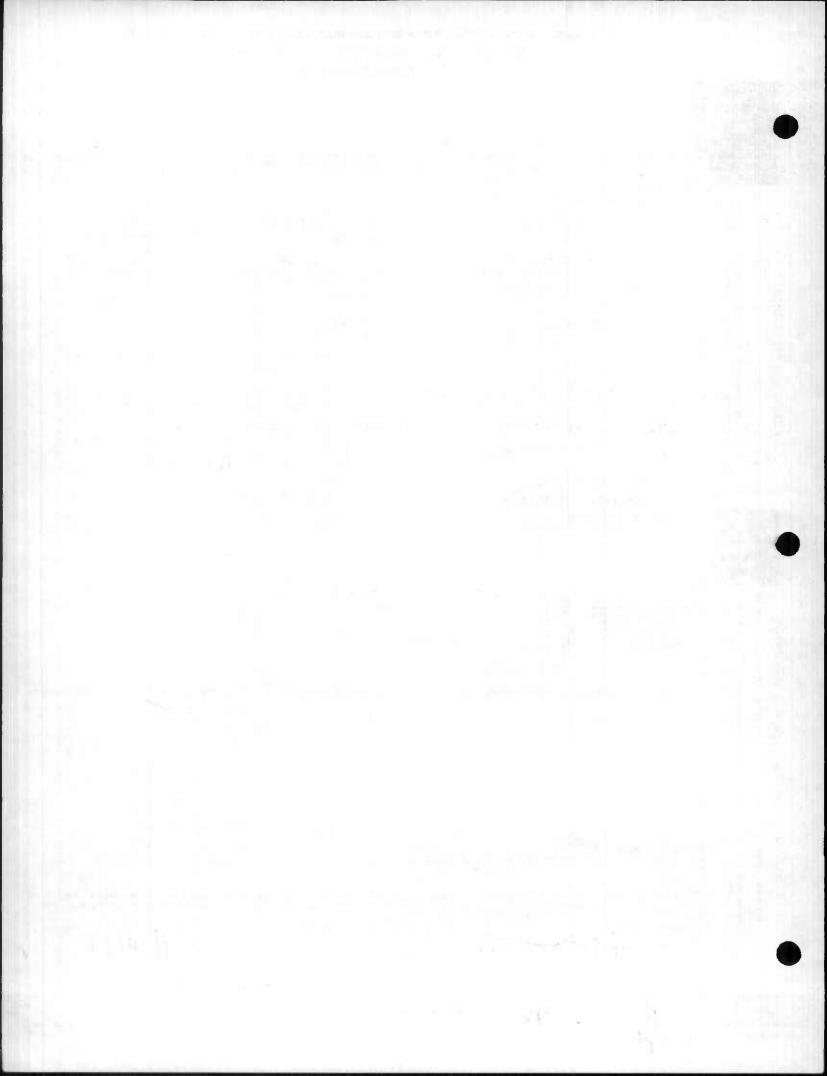


State of Maryland / Department of Health and Mental Hygiene

				(Certificate o	f Death	Re	eg. No. 98	12269		
Physici	an	1. Decedent's Neme (First, Middle, Las		DIID			2. Dete of Deet Month		3. Time of Deeth		
/Medic		ANANIAS		PER			JANUAR!	Y 9.1998	4:32p.m.		
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Funeral Director		346-40-976 Usual Residence of Decedent	ĎM 2□F 6	9 Y	Months Dev		8. Dete of Birth Month, Dey, NOV- 15,	1928 N.	thplece (State or Foreign buntry)		
yland		10a. State 10b. County	10c.	City, Town	or Location	/			10d. Inside City Limits		
d 21215-0020 filed within 72 hours after death with the Manyland bygiene. ther than "natural", or items 23s or 28s-1 show int, the Medical Examiner must be maithed at	ctor	MD. Charl	es =	Inc	iau /	kad			1 D¥6s 2 □ No		
	ai Director	10e. Street end Number 5301 Smith	Dr.	11	Og. Citizen of Whet Co						
- daa	Funeral	11. Maritel Status	12. Was Decedent Ever in Armed Forces?	U,S.	206 13. Was Decedent of If Yes specify Co	f Hispenic Origin? (Suban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame			
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		231 Fert1. Enter the disease, or comp shock, or heart feilure. List only o	lications that caused the de	ath. Do no	enter the mode of d	ying, such es cerdiad	or respiretory erre	est,	Approximate		
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Examiner		resulting in death)			nsequence of):	K					
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Vithii To th	Σ	29b. Signeture end title of certifier			29c. Lice	nse number	29	d. Dete signed (Monti	h, Dey. Year)		
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		30. Neme end eddress of person who co	ompleted cause of deeth (It	em 23e) (T		0332		ANOAKI I	2, 1990		
		KRISHAN MATHUR	, M.D. P.O	. BO	x 2729.	LA PLATA	, MD	20646			
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Registr	ar	JAN 3 0 1998	fiche Davidson-14	ndalle							

State of Maryland / Department of Health and Mental Hygieneg 8 02270

						C	ertifica	ate of	Death		Reg. No.	U	2210	
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п	Physic /Medi		La	vina M	ae	Del	TTIW			January	Day 7 17, 19		10:15 AM	
1	Exami		4a. Facility Nama (If not institution, given	a street and number)					4b. City, Town, or				10113 111	
			Dennett Ro	ad Manor N	ursi	ng Ho	me		0aklaı	nd	G	arret	t	
	Funeral	2	5. Social Sacurity Number 6. 5	Sex 7. Ag		last birthda	v) If Und	der 1 Year	r If Undar 24 Hrs	8. Date of Bir	h		laca (Stata or Foreign	
	Director		216-24-0226 Usual Residence of Decedent	1□ M 2\\ F	80	Yrs.	Month	s Days	Hours Min.	OCT.	26,1917	West	Virginia	
	/lend		10a. State 10b. County		10c. Cit	y, Town or	Location					10	Od. Inside City Limits	
	Mer	Ď	MD Garrett Oakland										1 ☐ Yes 2 No	
	1 284 r	Director	10e. Street and Number				10f. 2	Zip Code	oakrand		10g. Citizen of \	What Coun	try?	
	30 o		072 11	tton Road					21550			T C A		
	res 2	Jer	11. Marital Status	12. Was Decedent		,S. 13	3. Was De	cedent of	21550 Hispanic Orlgin? (S	pecify Yas or No		U.S.A		
Baltimore, Maryland 21215-0020 permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryland Depertment of Health end Mental Hygiene. Important: if Item 27 is marked other than "naturar", or Items 23e or 28e-f show shipry or other treumatic event, the Medical Exprise must be notified at once.	by Funeral	1 ☐ Navar Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorcad	Armed Forcas? 1 Yes 2 X If Yes, Giva Year or Dates:					Hispanlc Orlgin? (S ban, Mexican, Puerl Specify:	o Rican, atc.)		ck, White, o	elc.		
	2 ho	Completed	15. Decedent's E			16a. Dec	edent's U	sual Occu	pation	931	16b. Kind of B	usiness/Ind	lustry	
	ple	(Specify only highast gra Elementery/Secondary (0-12)	ade completed) College (1-4or !		(Git	ve kind of to DO NOT	work done use retin	during most of wo	rking					
	3 wit	E	12th	College (1-40)	, ,			Ins	pector		A	erosp	ace	
9	othe	Bec	17. Father's Name (First, Middla, Last)					18. Mother's Na	me (First, Middle,				
ō	fenta fenta ked ked dic ev	To B	Wallace	Edgar	D	orsey			Magg:	ie -		Hum	phrevs	
a	shot shot		19e. Informant's Name/Relationship (ess (Stree	et and Number or Ru		er, City or Town,		-	
Ξ	alth e		Arthur W. DeWitt	/Hushand		97	3 H111	ton	Rd., Oak	and MD	21550			
e,	s 1 e		20a. Method of Disposition		20b. F	Place of Dis	position (A	Vama of		Date	20c. Location -	City or To	wn, Stata	
Ē	ent o ent o y or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special						1	1 /00 /00	/20/98 Oakland, Maryland			
	ortan ortan Injur		21. Signature of Funeral Service Lice		Gar				Gardens less of Facility					
ñ	Depermine Depermine Depermine Depermine Depermine Depermine Depermine Department of the Department of		> Bradly 8	Coult				3	32 S. Seco	-	Oaklan			
	Physician [*]		23a. Part1. Entar the disease or com shock, or heart failure. List only	plications that caused one ceusa on each li	tha daat ne.	h. Do not e	inter the m	oda of dy	ring, such as cardia	c or respiratory a	rast,		Approximata Interval Between Onsat and Death	
	/Medical		Immediata Causa (Final disease or condition	CVA									3 weeks	
	Examiner		resulting in deeth)	8.	Due to (c	ras a cons	equence o	of):					3 weeks	
Н	D #	ner	Peripherialvascular disease										Years	
	nd	Examiner	Sequentially list conditions,	ь		ras a cons	-		Lacuse				rears	
Š	lan e	Ě	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									į		
00/00	rificete be executed ng physician end es the buriel-transit	Medical	that initiated events resulting in daath) Last	C. —	Due to (or as a consequenca of):							1		
5												1		
200	th ce	an		d								-		
	death he atter ed for u	sici	Part II. Other significant conditions of	contributing to death b	ut not res	ulting in the	underlying	g cause g	ivan in Part I.	23b. Dld	obacco usa co	ntribute to	the causa of death?	
	es that the death ce igned by the attendi be deteched for use	by Physician/	ASHD								1 Yes 2 No 3 Probably 4 U			
or vital necords,	been s	Completed t									an autopsy med?	con	ore autopsy findings uilable prior to inpletion of cause death?	
-	0 - 0	E								10	res 2∭ No	1 [Yas 2(X) No	
0	certificate rector, pa	0	25. Was case referred to medical	26. Place of Death (Check only one)									100	
>	Physician: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 No	Hospital:	nt 2	ER/Outpati	ient 3 :	DOA O	th ar:	fome 5 ☐ Resid		er (Spenih	•)	
Attending Physical Circles of the funeral disperse of		27. Menner of Death	28a. Date of Inju (Month, Da		28b. Time	of	28c. Inju			now injury occur		/		
	atio	1 XNatural 5 Pending 2 Accident investigation		y Year)	Injury	М		Yes 2 No						
DIVISION	2 4 9 E	Certification:	3 Suicide 6 Could not be determined	e 28e. Pleca of Injuding, etc	ury - At ho	ome, farm, s	street, fact	ory, office			cation (Street end Number or Rural Route Number, v or Town, Stete)			
	To the Hospital within 24 hours To the Funeral completely filled	edicai C	29e. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of niner: On the basis of and manner sta	examina	wledge, ded tion end/or	eth occurre Investigati	ed et the ton, in my	ime, date and place opinion, deeth occu	, end due to the irred at the time,	cause(s) and ma date and place,	inner as sta and due to	ated. the cause(s)	
	within 2 To the	Me	29b. Signature and title of certifier	3,11101 311			2	9c. Licen	se number		29d. Date signe	d (Month, L	Day, Year)	
	- s - ö		LIV								1/1	0 9	5	
			7					D	15333		117		V	
		٨	30. Neme and address of person who											
		4	Dr. Thomas G. Jo 31. Date filed (Month, Day, Year)				Fourt	h St	., 0aklar	nd, MD 2	1550			
	Sta Registr		or. Date filed (Month, Day, Year)	32. Registr	ai s Signa	Lear Ro	dell							

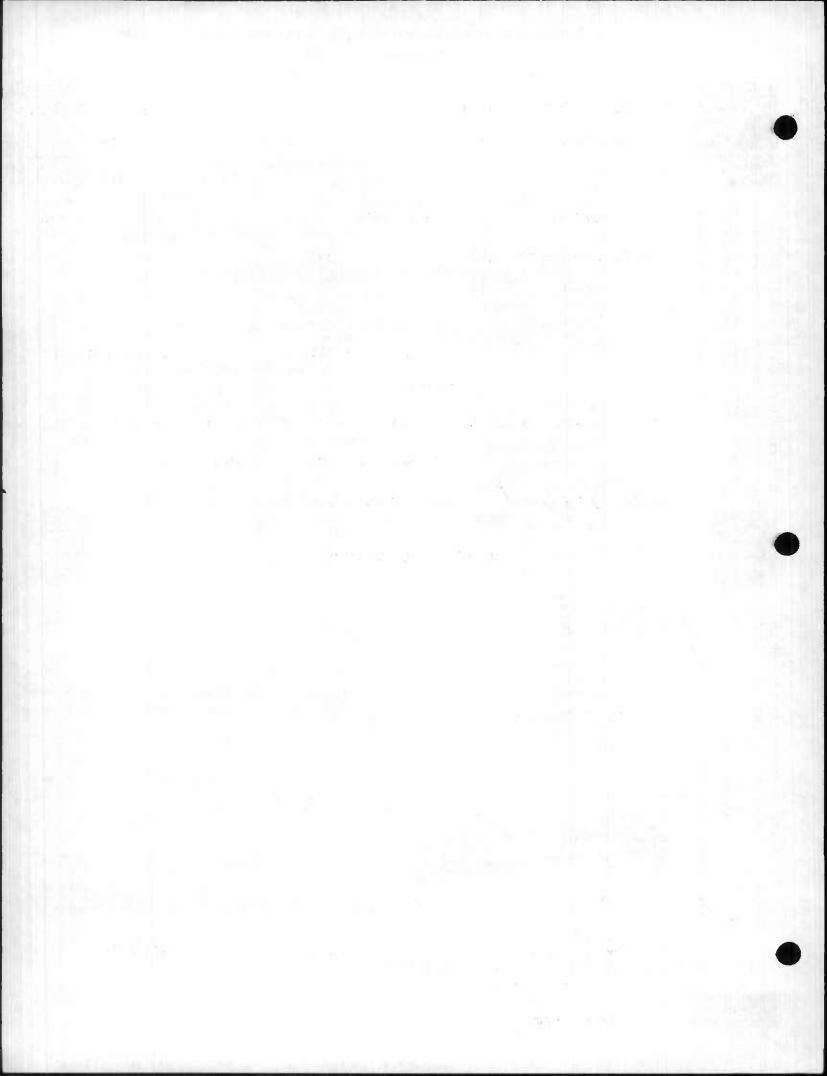


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Year HARRIET VIRGINIA DEBERRY **JANUARY** 1998 13, 8:12 P.M /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 2534 BOILING SPRINGS ROAD DEER PARK GARRETT 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Deys Hours 214-32-3475 Yrs Director 61 AUG 28 1936 MARYLAND Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mentel Hygiene. Important: if Item 27 is merked other than "natural", or Herne 23a or 28a-f show any injury or other treumatic event, the Modical Event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD GARRETT 1 ☐ Yes 2 No Director DEER PARK 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2534 BOILING SPRINGS ROAD 21550 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yee or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 N Married 1 Yes 2 No Specify: g Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL BUS DRIVER TRANSPORTATION 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be WALTER BECKMAN RACHEL LAURA 10 SCHMIDT 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVERETT DeBERRY - HUSBAND BOILING SPRINGS ROAD DEER PARK, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 1/16/98 DEER PARK, MD 4 ☐ Donetion 5 ☐ Other (Specify) DEER PARK CEMETERY 22. Name end Address of Fecility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKALND, MD 21550 X 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Betwe Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) METASTATIC CA OF COLON YEARS Examiner Due to (or es e consequence of) Examiner The law requires that the deeth certificate be executed physician and the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initiated events resulting In death) Lest Due to (or as e consequence of): P.O. Box 68760. Physician/Medicai Due to (or es e consequence of). 88 ettending use 10 ed by the e Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? signed by t d be detach 1 ☐ Yes 2 No 3 Probably 4 Unknown HIGH BLOOD PRESSURE Division of Vital Records, þ 24b. Were autopsy findings eveileble prior to Completed 24e. Wes en eutopsy performed? peen completion of cause of deeth? has page 2 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: director, Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No Lo 1 Inpatient 2 ER/Outpetient 3 DOA After this funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending efter death. 1 Yes 2 No investigation 2 Cl Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours e Hospital 29e. Certifier 1<mark>Ճ Certifying Phyeician:</mark> To the best of *m*y knowledge, death occurred et the time, date end placa, end due to the ceuse(s) end menner as steted. Medicai 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) and manner stated. To the To the To the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5198 D15333 10 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) THOMAS G. JOHNSON, M.D. 311 N. FOURTH ST. OAKLAND, MD 21550 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State

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JAN 15

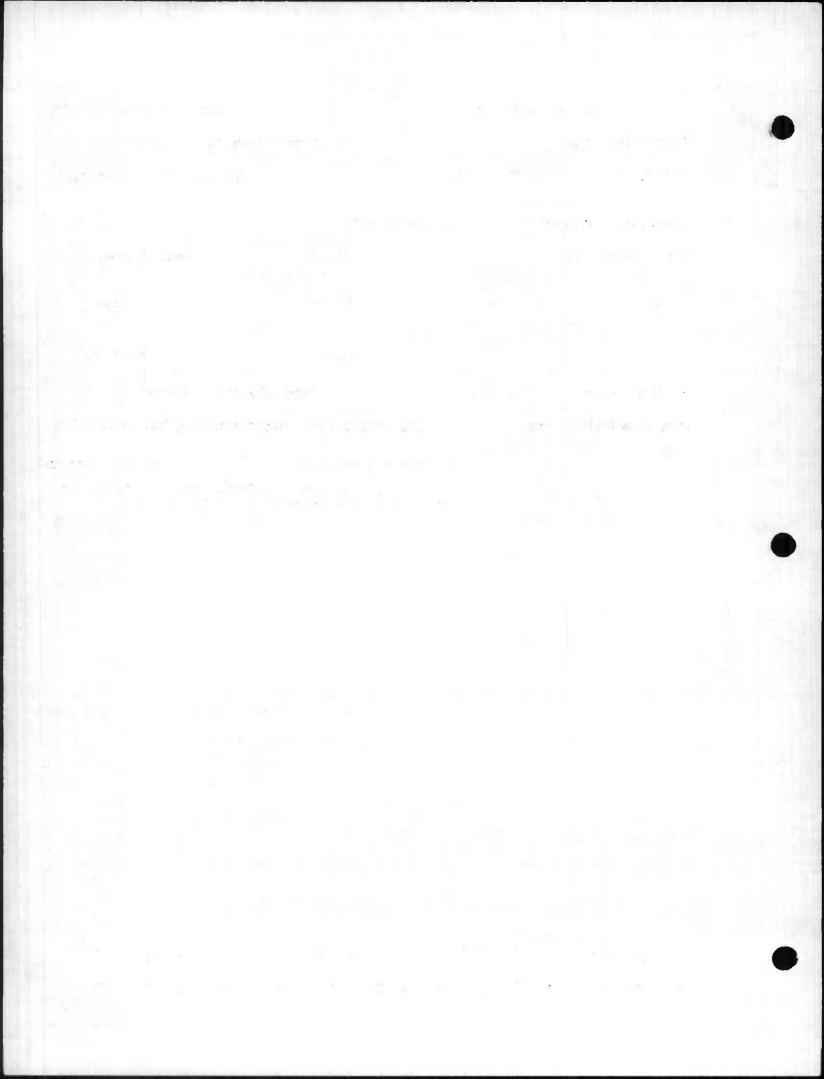
Registrar



State of Maryland / Department of Health and Mental Hygiene

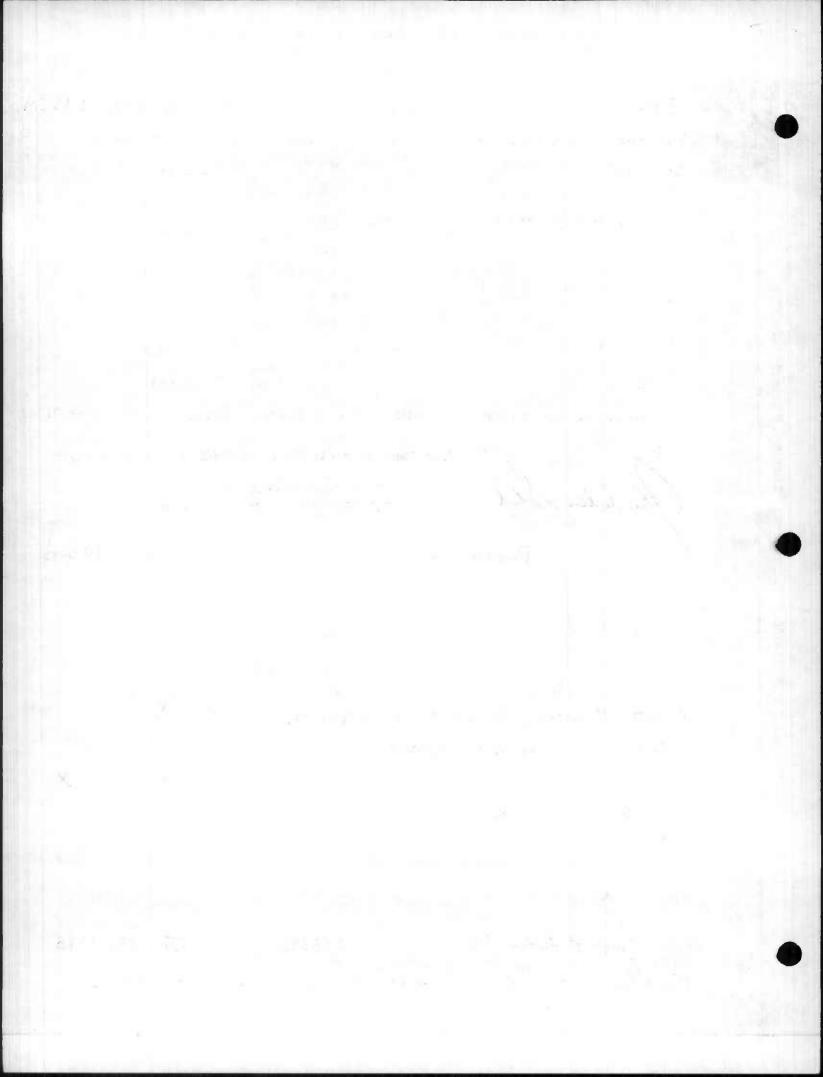
Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** 1998 Beatrice Marie Davis January 13 6:00pm /Medical 4a. Facility Nama (If not Institution, giva straat and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1200 Driver Road Marriottsville Howard 5. Social Security Number if Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Yea Birthplece (Stata or Foraign Country) **Funeral** Months Days Hours 1□M 28 F Yrs. Director 219-32-7147 80 Oct 28, Maryland Usual Rasidance of Decedent the Marylend 10e Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be nothlied at 1 Yes 2 No Director Maryland Howard Marriottsville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 8 items 23a 1200 Driver Road 21104 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Rece - American Indien, Black, Whita, atc. 11. Merital Status e filed within 72 hours efter of Hygiene. 1 Never Merried 2 Married 1 ☐ Yes 2X No If Yas, Giva Yaar or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: by 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 6 Homemaker Own Home 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middla, Maldan Surnama) . Peges 1 end 2 should be fill trans of Health end Mentel Hant: If item 27 is marked oth jury or other traumatic even Be James G. Ross Mary Elizabeth Riesett 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Carole Neff/Daughter 1200 Driver Road Marriottsville, Maryland 21104 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 XBuriel 2 Cremation 3 Removel from Stete permit. Pege Department of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) 1-17-98 Elkridge, Maryland Meadowridge Cemetery 21. Signetura of Funarai Sarvice Licenses 22. Nema end Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. n a 60 4 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Entar the diseasa, or complications that caused the deeth. Do not antar the mode of dylng, such es cardiac or respiretory arrest, shock, or heart failura. List only ona causa on aach lina. Approximata Intarvel Batwean Onsat and Death Physiclan /Medical Immediata Cause (Finel disaasa or condition rasulting in death) a Interstitial Pulmonary Fibrosis Examiner Dua to (or as a consequence of): Examiner Pneumonia physician and the buriel-transit Hospital or Attending Physician: The lew requires that the deeth certificate be executed Sequantially list conditions, if eny, leading to immadiate cause. Entar Undarlying Cause (Disaase or Injury that Initiated evants rasulting In death) Last Due to (or es e consequence of): Box 68760. Physician/Medicai Due to (or es e consequence of): ettending p P.O. signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Records, λq been si 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 hes 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital s efter death.

el Director: After this certificate led in by the funeral director, pr Be 25. Was casa rafarred to medical axaminer? 28. Placa of Death (Check only one) Hospital: Othar: 4□ Nursing Homa 5□ Rasidance 8 □ Othar (Specify) Certification: To 1□ Yas 2√ No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending invastigation 1X Natural 1 Yas 2 No 2 Accident 3 Suicida 6 Could not be 28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 - Homicide 24 hours 29a. Certifian 1 Contifying Physician: To the best of my knowledga, death occurred at tha tima, date and place, and dua to tha causa(s) and manner as stated. within 24 hou To the Funel completely fil Medical 2 Medicat Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to the ceuse(s) end mannar stated. To the 29b. Signetura and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) D50727 January 15, 1998 30. Nama and address of person who complated cause of death (Item 23a) (Type, Print) Michael Gallagher, MD St. Agnes Hospital 900 Caton Avenue Baltimore, Maryland 32. Registrer's Signature 31. Data filed (Month, Day, Year) State JAN 1 6 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene

	- 20				Certific				Reg. No.	U	2213
Physic	lan	1. Decedent's Neme (First, Middle, Las		JAMPH	\			2. Date of De Month	Dev	Year	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, give		JAMPK	MAN		4b. Citv. Town, o	T Location of Deat		998	1,10 1,1
Exami	ier	HOWARD COUNTY		420H_	ITAL		Colun			WAR	5
Funeral Director	F	5. Social Security Number 6. So		81		der 1 Year hs Days	If Under 24 Hr Hours Mir	8. Date of Bir (Month, De Ocotoer	3, 1916	9. Birthpli Count VII'9	ace (State or Foreign Inia
and		Usual Residence of Decedent 10e. Stete 10b. County		10c. City. To	wn or Location					10	d. Inside City Limits
Maryi Heho fied a	tor	Maryland Howard	County		Ellico	tt Ci	tv				1 ☐ Yes 2 ☐ No
th with the 23a or 28a	al Director	10e. Street and Number 9315 Route 99				Zip Code 21.0	18		10g. Citizen of V USA	Vhat Count	ry?
"natural", or items 23s or 28s-f show solical Examinet must be notified at	by Funeral	11. Marital Status 1 Never Merried 2 Married 3 CN/Vidowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:	Ever in U,S. Io			lispanIc Origin? (an, MexIcan, Pue Specify:	Specify Yes or No irto Rican, etc.)		e - America k, White, e Whit	tc.
72 hc natur	eted	15. Decedent's Ed (Specify only highest grad	ucation de com <i>pleted)</i>	16	a. Decedent's L (Give kind of	sual Occup	eation during most of width	orkina	16b. Kind of Bu	isiness/Ind	ustry
be filed within 72 ho ntal Hygiena. Id other than "natur event, the Medical	Completed	Elementery/Secondary (0-12)	College (1-4or 5-	+)	homem		d)		home	2	
al Hygie other		17. Fether's Name (First, Middle, Last)	7 111		rioine.ii	UNCL	18. Mother's Na	ame (First, Middle,			
should be ad Mental markad o	To Be	George Hodge					F1c	ora (un	known)		
nd 2 should be filed within 72 hours af aith and Mental Hygiena. 27 is merkad other than "natural", or er treumatic event, the Medical Exam		19a. Informant's Name/Relationship (7 Mr. Charles E. Dan		19	9345 Mi	ess (Street 11bro	end Number or F ok Road,	Rural Route Numb Ellicot	er, City or Town, tt City,	State, Zip	Code) land 21042
permit. Pages 1 and 2 should by Department of Health and Menta important: if item 27 is merked any Injury or other treumatic espace.		20e. Method of Disposition XXBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			of Disposition (ery, crematory tlawn M		∞) al Gdn.	Date 16JAN98	20c. Location -		
permit Depart Import any In	21	21. Signature of Funeral Service Licens	111	M00535	Sla	ck Fu		me, P.A.	21042		
		23a. Part1. Enter the diseese of compositions of heart failure.	lications that caused tone cause on eech line	the death. Do	not enter the n	node of dyir	ng, such es cardia	faryland ac or respiratory a	rrest,		Approximete Interval Between
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. PHEUM								Onset and Death
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E 0 6	Medical	resulting in death) Lest	c	Due to (or as e	consequence	of):					
daath cer e attendin ed for use	clan									j	
d by the	y Physician/N	Part II. Other significant conditions co			in the underlyin			23b. Did	1/		the cause of death?
	Completed by	STROKE, CORON	ARY ARTE	RY DIS	ENSE				an autopsy med?	ava	re autopsy findings ilable prior to apletion of cause eeth?
sicien: The law certificate has t lirector, page 2 s	Com							10	Yes 2 No	1 🗆	Yes 2 No
ysicien: The I is certificate ha director, page	Be	25. Was case referred to medical examiner?			1.4			eath (Check only o	one)		
this ald	. To	1 Yes 2 No 27. Manner of Deeth	Hospital:	-	Outpatient 3 I	DOA Oth	4 LI Nursing	Home 5 Residue			
i or Attending Phattar death. Director: After thialn by the funeral	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Dete of Injury (Month, Dey	Year)	Injury M		k? Yes 2 □ No		now injury occurr		
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After complately filled in by the funer	Certif	4 Homicide determined	28e. Place of Injurieur building, etc.	(Specify)				City or To			
Hosp 24 hos Fune ataly fi	edical	29e. Certifier (Check only one) 12 Certifying Phy	reician: To the best of iner: On the basis of a and menner stat	examination a	ge, death occurr nd/or investigat	ed at the tir ion, In my o	ne, date and place plnion, death occ	ce, and due to the curred at the time,	cause(s) and ma date and place, a	nner as ste and due to	ited. the cause(s)
within 2 To the	Mec	29b. Signature and title of certifier	1			29c. Licens			29d. Date signed	d (Month, D	ley, Year)
- 5 - 0		1	ellows, hu			D 3	8296		JAN	13,	1998
Ψ		JOSEPH GIBBONS M	95010	LO ANI	NAPOLIS	120,	ELLICO	rt City,	WP S	104	2
Sta Registr		31. Dete filed (Month, Day, Year)	QQQ 32. Registra	r's Signature	r Rardai!						



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

										711	G. 140			
	1. DECEDENT'S NAME (First	, Middle, Last)	Oueen I	rake						2. DATE OF DE MONTH	D	9 (YEAR 9 9 8	3. TIME OF DEATH SOSA M
	4. SOCIAL SECURITY NUME	ER	5. SEX	8. AGE (In yrs.	(ast hirthday)	IF UNDER	1 VEAD	IF UNDE	24 UDC	7. DATE OF BIS		,		IPLACE (State or Foreign
	427-08-94		1 □ M 2½∑XF	87	YRS.	MONTHS	DAYS	HOURS	MIN.	(Morith, Day, 09-2	7 – 27 –	10	Countr	
	9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY	, TOWN	OR LOCATI	ON OF DE			_	INTY OF D	
8	Greenbelt	Nur	sing Ho	me			Gr	eenk	elt			Pri	ince	George's
5	RESIDENCE OF DEC	10b. COUNTY												
DIRECTOR	Maryland		ce Geor	ge's	10c. CIT	Y, TOWN	OR LOCA		Jppe	r Marl	Lbo	ro		10d. INSIDE CITY LIMITS? 1 X YES 2 NO
AL.	10e. STREET AND NUMBER						10	. ZIP COD	E			10g. CIT	IZEN OF V	WHAT COUNTRY?
FUNERAL	10405 Ra	ambli	ng Hill	Court	t			20	772				US	A
2	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S.						IC ORIGIN? (Spe		or No—		E — American Indian, k, White, etc.
ВУ	1 Never Married 2 3 Widowed 4 Divo		IF YES, GIVE Y					2 10 NO			etc.j		Speci	
8	15. DEC	EDENT'S EDUC	CATION		DECEDENT'S					16b, KIND	OF BUS	SINESS/ING	DUSTRY	
	Elementary/Secondary (0	y highest grade	College (1-4 or 5		(Give kind of life. Do NOT u	work done se retired.)	during mo	st of worki	ng					
COMPLETED	10th				Нс	mem	ake	r				Priv	vate	;
ő	17, FATHER'S NAME (First, M							18. MOT	HER'S NAI	ME (First, Middle,	Maiden	Surname)		
BE (John	Henry	y Boyd							Kizzie	e F	ulfo	ord	
2	19a. INFORMANT'S NAME (7									loute Number, City				
-	Barbara W		/Daught			-			iue,	Sprin				
	20a. METHOD OF DISPOSITI 1 Burial 2 Crematio 4 Donation 5 Other	n 3X X Remo	oval from State	cemetery, o	Crematory or o	ther place)							City or To	
	21. SIGNATURE OF FUNERA		ENSEE	- 15umi	rall	22.	NAME A	ID ADDRE		CILITY				ississippi
è	▶ k/	Λ	0 -	- '						ins Fu				
_	22 PART I Franch	H.	Vercen	he			747	4 La	ndo	ver Ro	oad	, la	ando	ver MD
	23, PART I. Enter the d shock, or he IMMEDIATE CAUSE (Fin	pert fellure, l	List only one cer	ise on each il	deeth. Do i ne.	not enter	the mo	de of dy	ing, suct	es cerdiec o	r respi	retory sn	rest,	Approximate Interval Between Onset and Death
	disesse or condition resulting in death)	+	ANG	20566	Enon'	c C	m	1004	KWI	an Di	12	619		Years
İ			OUE TO	(OR AS A CONS	SEQUENCE O	F):								
CERTIFICATION	Sequentielly list conditi		DUE TO	(OR AS A CONS	SEQUENCE O	FI.								
¥.	If sny, lesding to immed csuse. Enter UNDERLYI	NG		(,								
三	CAUSE (Disesse or Inju that initiated events	מ מ	DUE TO	(OR AS A CONS	EOUENCE O	F):								
토	resulting in death) LAS	T	1.											
2	DART II Other significa	na na mallala n		4=00.4										
MEDICAL	PART II. Other significa								given in i		MAS AN PERFOR	AUTOPSY IMED?	24b.	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
ă	PANKINSO	NE 131	1 ENDS	MAIC	195	1362	527	14		1 🗆	YES 2	NO		OF DEATH?
ec	CENERAL	INFAI	SCI.ON	1043	PHAG	A								1 YES 2 NO
PHYSICIAN:	DID TOBACCO U		RIBUTE TO CA					UNC	ERTAIN	1 🗆 📗				
0	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		ACE OF OEA	OTHE!								
₹	1 YES 2 NO		1 Inpatient 2			4 Nur	sing Hom	_	aldenca	8 Other (Spec				
	_	Pending	28a. DATE OF (Month, D	lay, Year)	28b, TIM	IURY		RK?	7 400	28d. DESCRIBE	HOW II	NJURY OC	CURED	
à l	2 0 0-1-14-	investigation	28a PLACE C	F INJURY — At	home form			YES 2	J NO	AAA I OOITION	(0			
COMPLETED		Could not be detarmined	building,	etc. (Specify)	riome, term,	ation, tac	iory, ornic			28t. LOCATION City or Town		ina Number	OF HUNE! H	ioute Number,
۳	29a. CERTIFIER 1 CERT	IFYING PHYSIC	CIAN: To the best of	my knowledge	doeth islam				Syre	edici = av		A pesson		
ž I														i) and manner as stated.
	29b. SIGNATURE AND TITLE						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				ace, en	0 002 10 11	re ceuse(a)) and manner as stated.
BE	Pr. 11	OF CERTIFIER	mol.	()					ENSE NUM			29d. OAT	E SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CALL	SE OF DEATH /IT	FM 27) /5	Printl		N	18	J 2	_	-		ry 9, 1998
	PAVI A.	DEV	RE MO	4203	Que	557X	ALVE	Rel	M	52-	11/2	M	D 26	7875
	31. DATE FILEO (Month, Day,		32. PEGISTR	R'S SIGNATURE	Carlott								_	

NAME OF STREET

WRC 98-0093-033 FRANCES DUKE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 8 02275

ES							Cei	rtificate	e of	Death			Reg. No.	U tua		
			1. Decedent's Nan	ne (First, Middle, La	ist)							2. Dete of De		Vaar	3. Time of Dea	th
	Physici /Medio		FRANCES	ELIZABET	H DUKES							JAN'.	06, 199	98 ^{ear}	8:00 P	Μ.
	Examir	_	4e Fecility Name ((If not institution, giv		nber)						ocation of Death		of Deeth		
		•	4307 W	VILL ST.						CAPI'	TOL	HEIGHTS	P.G.	COUN	TY	
	Funeral		5. Sociel Security I	Number 6. 5	Sex	7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Bir (Month, Da	th v. Year)	9. Birthple	ace (State or For	reign
	Director		577-42-8 : Usuel Residence	145	1 M 261 F		67 Yrs.			1100.0					KIE, N.C.	
	yland		10a. State	10b. County		10c. Ci	ty, Town or Lo	cation						10	d. Inside City Lir	nits
	Mar	to	MD	PRINCE	GEORGES	CAP	ITOL H	EIGHT	S						1X Yes 2	No
	h the	Director	10e. Street and Nu					10f. Zip					10g. Citizen of	Whet Count	ry?	
	h wit	9	4307 WT	LL STREET				2	074	3			UNITED	STATE	S	
	dea	Funeral	11. Maritel Status		12. Wes Dece Armed For	dent Ever in U	J,S. 13.				gin? (Sp	ecify Yes or No Rican, etc.)		ce - America	an Indien,	
050	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show Its Medical Examiner must be notified at	by Fu	1 Never Man	ried 2 ☐ Married	1 Tes If Yes, Giv Year or De	2 X No		1 ☐ Yes 2			, r donto	1110411, 010.7	Specif	fy:		
0	natural',	Pe		15. Decedent's E	ducetion		16e. Dece	dent's Usua	l Occup	oation			16b. Kind of B	BLA!		
21215-0020	7 uic	Completed	(Spe Elementary/Sec	ondan (0.12)	ade completed) College (1	Aor 5.1	(Give	kind of wor DO NOT us	k done e retire	oation during most d)	of work	ring				
21	filed with Hygiene. ther there	E	12		0	-401 34)	CAFE	CERIA	WOR	KER			PRIVAT	E		
	other of the	Bec	17. Fether's Neme	(First, Middle, Last)					18. Mothe	r's Nem	e (First, Middle,	, Maiden Sumer	me)	PERM	
Maryland	s 1 and 2 should be filed within f Heelih and Mentel Hygiene. Item 27 is marked other than other traumetic event, train	ToE	WILLIAM	ASKEW						LOUT	HEL	BUNCH				
an	2 should and Men is marka sumatic		19e. Informent's N	lame/Relationship (Type, Print)		19b. Maili	ng Address	(Street	end Numbe	r or Rur	ral Route Numb	er, City or Town	, Stete, Zip	Code)	
	and 2 selth a n 27 is		FLORINE	GILLESPI	E/DAUGH	TER	2206	COLUM	IBIA	AVE.	LAN	DOVER,	MD 2078	35		
Baltimore,	ges 1 and t of Heelth If item 27 or other t		20e. Method of Dis			20b. I	Place of Dispo cemetery, crea	sition (Nam	ne of ther pla	ce)		Date	20c. Location	- City or Tox	vn, Stete	
E	Peges net of nrt: If its iry or o	njury		ÖCremation 3 ☐ 5 ☐ Other (Specif		State	TROPOL				1	1/10/98	ALEXANI	DRIA.	17 Δ	
alti	permit. Peg Department Important: i any injury o		21. Signature of F	uneral Service Lice	nsee							FUNERAL			722	
m	Depa Impo any li		D. Anh	d Monta	n. 11	how the	4									
			23a, Parti, Enter	the disease, or own	plications that or	aused the dear	th. Do not en	538 MA	ARLI e of dvi	BORO P	IKE	FOREST or respiratory a	VILLE, 1	MD 207	747 Approximate	
4	Dharatatan		shock, duher	the disease, or bern art laiture. List only	one sause on e	ach line.									Interval Between Onset end Deetl	
	Physician /Medical		Immediate Cause	(Finel	11	1	. ,	11		1	2	ren				
	Examiner		disease or condition resulting in death)	on	e. 144/	let en-	sere C		150	alex	D	rees	٤			
	and the	e				Due to (or es e conse	quence of):						i		
	betr	Examiner			b	Due to /										
	exect n and iel-tra	Exa	if any, leading to it	onditions, mmediate		Due to (or es a consec	querice or).								
68760,	sicia bur	cal	Sequentially list or if any, leading to in ceuse. Enter Und Cause (Disease or that Initiated event	r Injury	c	Due to /	or es a consec	monoo off.						-		
89	thet the death certificate be executed ed by the ettending physician and detached for use as the bunei-transit	edical	resulting in death)	Lest		Due to (t	or es a corrsec	querice ory.								
X	nding use	M			d											
Bo	thet the death cered by the ettendin	Physician	Port II Other elani	ificant conditions of	ontributing to de	ath but not rea	rulting to the u	nderhina er	nuco di	van in Part I		23h Did	tobacco use co	ontribute to	the cause of de	ath?
P.0	t the d	hys	Tertil. Other algin	meant conditions t	Orthibuting to de	atti but not 16	suiting in the u	indentying or	ause gr	ven in raiti.			Yes 2 No	3 Prob	1	
	es thet igned t be det	by P											100 10110	0000	7	
Records,	requires been sign hould be	D D											an autopsy		re autopsy findin	ngs
00	- AJ (7)	Completed										perio	ormed?	con	oilable prior to apletion of cause death?	•
Re	The law ate hes b page 2 s	E G										٨.	Yes 2 No	. 1	1	
a	iclan: The certificate rector, pag	000	OF Management	and to made at						20.81	15		-	1	Yes 2∐ No	
5	certif	00	25. Was cese refe exeminer?		Hospital:		Tento:		Ott	har-		th (Check only			.1	
of Vital	Physician: r this certific rral director,	- To	1 X Yes 2 ☐ 27. Manner of Dee		-		ER/Outpetier 28b. Time o		A	4 L Nu	irsing Ho		dence 6 Ot how injury occu		,	
-CO	Jing After fune	ton	1 Matural	5 Pending investigatio		of tnjury h, Day Year)	Injury	м	8c. Inju Wo	rk?]Yes 2∐l	No					
S	Attending or death.	Ica	2 Accident 3 Suicide	6 ☐ Could not b	99 Place	of tniury - At h	nome, farm, st					28f. Location (Street end Num	ber or Rura	Route Number,	
Division	or A Direction	Certification:	4 Homicide	determined	buildir	ng, etc. (Speci	fy)	,	,			City or To	wn, State)			
	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier	1☐ CertifyIng Ph	vsician: To the	best of my key	owledge, deet	h occurred s	at the ti	me, date en	d plece	and due to the	cause(s) and m	nenner as st	ated.	
	Hos 24 h Fun etely	edical	(Check only one)	2 Medical Exam		isis of examina										
	o the	Me	29b. Signeture end	d title of cartifier				29c	. Licen:	se number			29d. Date sign	ed (Month, I	Day, Year)	
	F3F8		1	10	111.	- /			C	.C.M.	E.		JAN. 07			
	12)		1/h	elder 1	VICTURA	of res	D	5 :- 0								
-	131		30. Neme end sdd	lress of person who	completed caus	e probeeth (Ite	m 23a) (Type,	rnnt)								

State

Registrar

THEOREME MIKING 31. Dete filed (Month, Dey, Year) JAN 12 1998

111 Penn Street, Baltimore, Maryland 21201

32 Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene 98 02276

					Certificat	e of	Death			Reg. No.			U
		1. Decedent's Neme (First, Middle, L	ast)						2. Dete of De	ath		3. Time of	Death
	sician edical	Laurinda Teotor	io de Olive:	ira					Month January	Day 10.	1998	4:20	p.m.
	niner	4e. Facility Name (If not institution, g					4b. City, To		ocation of Deatl	1	ounty of Death	1.020	PVIIIV
1		6310 51st Avenu	e				River	dale		Pri	nce Ge	orge's	
Funer Direct		188-30-3211	1□M 2ME	yrs. last birth	Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Nov. 9	th V Year)	9. Birth	place (State on ntry) uga1	r Foreign
Meryland f show	or	Usuel Residence of Decedent 10e. State 10b. County Maryland Prince		City, Town								10d. Inside Ci	
28s	Director	10e. Street and Number	George 5	KTAGI	10f. Zip	Code				10a. Citize	n of What Cou	ntrv?	
s 23e or	eral Di	6310 51st Avenue			20	737				U.S.	. A		
15-0020 or 72 hours effer death with the Menyland neturel; or Items 23e or 28e-1 show	d by Funeral	3 X Widowed 4 □ Divorced	12. Was Decedent Ever I Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	n U,S.			Hispanic Ori en, Mexicar Specify:		ecify Yes or No Ricen, etc.)		Race - Americ Black, White, pecify: Wh:		
4m C	Completed	15. Decedent's I (Specify only highest g	Education rade completed) College (1-4or 5+)	16a. I	Decedent's Usua Give kind of wo life. DO NOT u	al Occu rk done se retire	pation during mos nd)	t of work	ing	16b. Klnd	of Business/In	dustry	
d 212 filed withir Hygiena. wther then	E S	Unavailable	College (1-401 3+)	Но	usekeep	er				Lelar	nd Hosp	ital	
be filed that dother event, is	Be	17. Father's Name (First, Middle, Las	it)		-		18. Mothe	er's Name	e (First, Middle,	Maiden Su	mame)		
	10	Antonio Teotoni	o Mendes				Mari	ia A	Anastac	ia			
re, Maryland s 1 end 2 should be file f Health and Mental Hy tem 27 is marked other other traumatic event	-	19a. Informant's Name/Reletionship	(Type, Print)	19b.	Mailing Address	(Stree	and Number	er or Rur	al Route Numbe	er, City or T	own, State, Zip	Code)	
CENL		Hirsilda O. Naza	rio - Daughte	r 703	9 Hunte	r L	ane, H	Hyatt	tsville	, Mary	land	20782	
altimore, mit. Pages 1 e pertment of Hea portant: if Item	þ	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from State	cemetery	Disposition (Nar , crematory or o	ther pla	/	11	Date / 1.2./0.0		tion - City or To		1
Baltimoi permit. Pages Depertment of Important: If it any Injury or or	OUCE.	4 □ Donation 5 □ Other (Special Service Lice		ale U	f Heave	d Addr	ess of Facilit	ty					rytan
- 40E	a	1 4. B.C	7 eise		4739 Ba	alti	more .	Aven	s Funer ue, Hya	ttsvi	lle, MI	2078	31
Physicia	,	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	plicetions that ceused the d y one cause on each line.	leeth. Do no	et enter the mod	le of dyi	ng, such as	cerdiac	or respiretory a	rrest,		Approximete Interval Beh Onset end [ween
/Medic	_	Immediate Cause (Final	P		onia							1 1	1
Examin	er	disease or condition resulting in death)	a		ensequence of):						1	a co	ys
	ě						Don		L'a		1	211	10.1
cuted	Examiner	Sequentially list conditions	b. Due t	o (or as a co	insequence of):	4	2011	ien	6740			a y	(Arthurs
68760, filcete be axecuted physician end st the buriel-transit		Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events			insequence of):	ele	u /	fee	iden	5		2 y	ars
ortifi ing	in/Medical	resulting in death) Lest	d. Chro	o (or es e co	nsequence of):	zue	Tim	e B	ulmon	my 1	Diseo	m 80	jens
O.O. BO) at the deeth ce by the attendinached for us	Physician/	Part II. Other significant conditiona	contributing to death but not	resulting In	the underlying o	euse gi	ven in Part I		23b. Dld	tobacco us	e contribute to	o the cause o	of death?
ds, P. (ires that the signed by detact	by Phy	Dysphag	ia						10	Yes 2	No 3□Pro	bably 4	Unknown
aw request been 2 should	Completed				<u> </u>					an eutopsy med?	av	ere autopsy f ailable prior to mpletion of c death?	0
- F # d	5								10	res 2 1	No 1[☐Yes 2☐	No
Vital I	Be	25. Was cese referred to medical examiner?					26. Place	of Deat	h (Check only o	ne)			
- 5 vo	2	1 ☐ Yes 2 No	Hospital: 1 Inpatient	≥ □ ER/Outp	patient 3 DC	OA Ot	her: 4 🗆 Nu	rsing Ho	me 5 Resid	dence 6	Other (Specif	(y)	
ing ing	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year	28b. Ti	me of 2 ury M	8c. Inju Wo	ryat rk? Yes 2 □		28d. Describe l	now injury o	ccurred		
	Certification:	3 Suicide 6 Could not determined		nt home, farr	n, street, factory	, office			28f. Location (S City or Tox	Street and N vn, State)	lumber or Rura	al Route Num	ber,
Di To the Hospital or within 24 hours afte To the Funeral Dir complataly filled in	edicai C	(Check only 2 Medical Exa	hysician: To the best of my i	knowledge, inetion and/	death occurred or investigation	et the ti	me, date an	d place,	and due to the	ceuse(s) an	d manner as s	tated.)
To the ithin 2 To the	Med	29b. Signature and title of certifier	and menner stated.				se number				Igned (Month,		
of one	\	Hayre,	Imentas		1	93	0111			Janu	any l	1.199	98
(4))		completed cause of death (Item 23e) (T	trea	Dr	Be	140	ville	Md	2070	5-17.	57
Regi	State	31. Dete filed (Month, Day, Year)	32. Registrar's Si	gneture	datt			~ ~		(_ , , ,	
Tiegi	Juli	JAN 12 19	70_		-								

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Jahuary 8, Proge Lorenzo T. Daniel 9:25 A.M. 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 6104 District Avenue Prince George's District Heights If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth February 4, 1932 9. Birthplace (State or Foreign 1 ☑ M 2 □ F Deys Hours Washington, D.C. 65 Yrs. 10h County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Prince George's District Heights 10f. Zip Code 10g. Citizen of Whet Country? 6104 District Avenue 20743 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces?
1 ⊠ Yes 2 □ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Black. 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantery/Secondery (0-12)
12th grade College (1-4or 5+) Mail Man U.S. Postal Service 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Elizabeth Newman Rhinehart Daniel 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Coda, Mrs. Deborah D. Jeter (Daughter) 6104 District Avenue District Heights, Maryland 20743 20b. Pleca of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 1 XBuriei 2 Cremetion 3 Removei from State National Harmony Memorial Park 1/13/98 Landover, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility Rollins Funeral Home, Inc. Approximate
Intervei Between
Onsat and Death 23a. Pert1. Enter the discrete for complications that caused the deeth. Do not enter the mode of dying, such as cardiac or shock, or heart fellars. Washington, D.C. Esophageal Cancer 2 years Due to (or es e consequence of): Malnutrition Due to (or es e consequença of): Due to (or es e consequence of): 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 2 X No 1 Yes 1 ☐ Yes 2 VNo

Physician /Medical Examiner

physiclan and s the burial-trensit

for usa es

signed by the at id be deteched for

should

page 2

cartificate

to the Hospital or Attanding Physician: initin 24 hours after death.

to the Funeral Director: After this cartifical propietely filled in by the funeral director; I

ithin 2 to the

The law requires that the death certificate be axecuted

P.O. Box 68760,

Records,

Division of Vital

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medicai

Physician

/Medical

Examiner

Funeral

Director

28a-f show

238 daath

Hems 2

permit. Pagas 1 and 2 should be filed within 72 hours aftar c Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examinations.

Baltimore, Maryland 21215-0020

the Medical Examiner must be notified at

Director

Funeral

Completed by

Be

the Meryland

With 5 5. Social Security Number

Usuel Residence of Decedent

578-42-0722

10a Steta

Mary land

11 Marital Status

10e. Street end Number

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated evants resulting in deeth) Lest

Immediete Causa (Final diseese or condition resulting in deeth)

20a. Method of Disposition

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case rafarrad to medical 1 Yes 2 No

27. Menner of Death 1 Netural 2 Accident 5 Pending investigation

6 Could not be determined 3 Suicide 4 Homicide

Hospitel: 1 ☐ Inpatient

28e. Dete of Injury (Month, Dev Yeer)

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28a. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Deeth (Check only ona)

28d. Describe how Injury occurred

Other: 4 Nursing Home 5 NResidenca 6 Other (Specify)

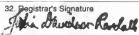
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

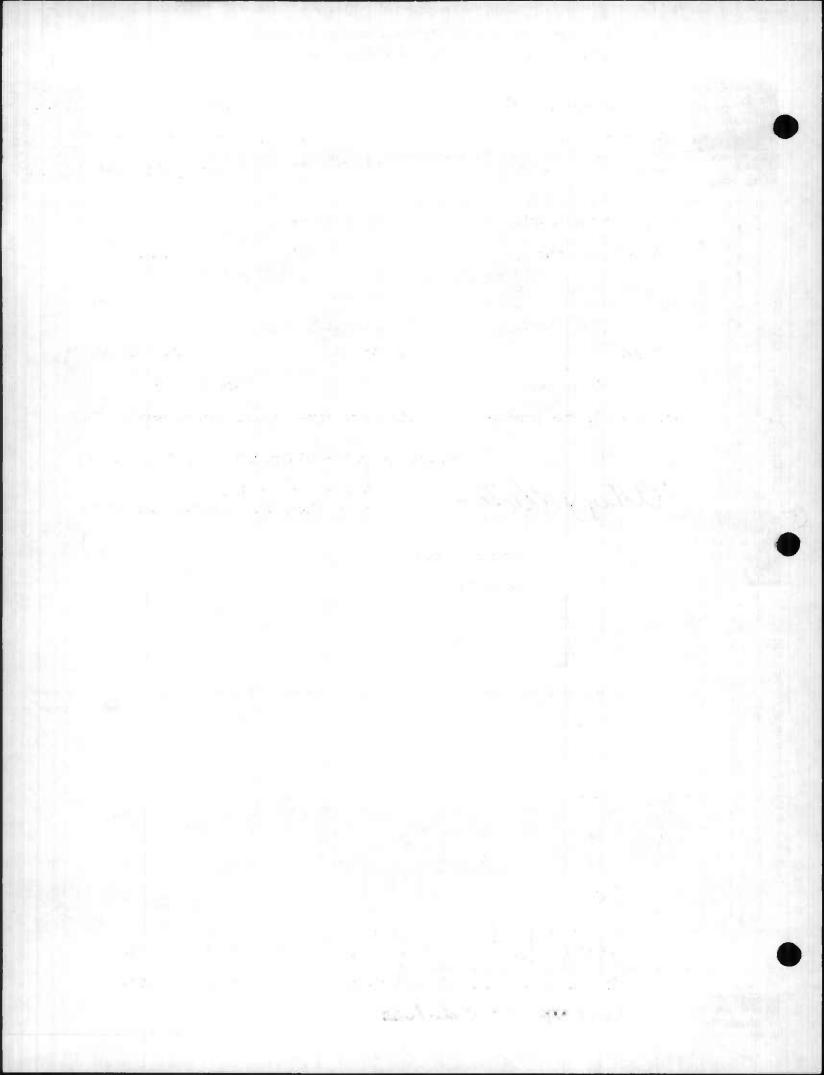
29e. Cartifier (Check only one) 29b. Signature a 1 Certifying Physicien: To the best of my knowledga, death occurred at the time, dete end pleca, end dua to tha causa(s) and menner es steted.
2 Medical Exeminer: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred at tha time, date end placa, end due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Tyon, Print)

David A. Morowitz, M.D. 5530 Wisconsin Avenue suite #1149 Bethesda, MD 20814

State Registrar 31. Date filed (Month, Day, Year) JAN 13 1998

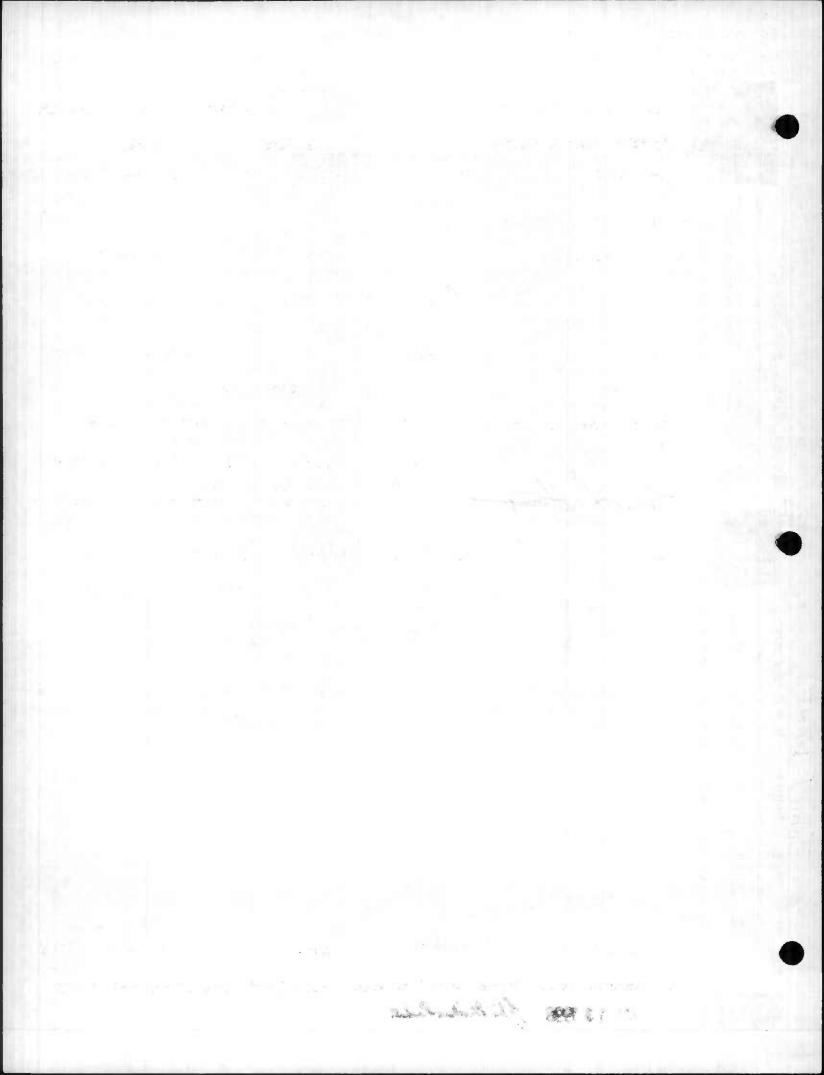




State of Maryland / Department of Health and Mental Hygiene 8

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ician		ecedant's Nama (First, Midd			.							_ Mon		Day	Year	3. Tima of Deat
dical	-	JOHN EDMOND	DAN'	_	R.					h City To	um orla	Janua		9	1998	8:22 P.M.
niner		Facility Name (If not institution							4	b. City, To		ocation of	Daam		unty of Death	1
-1	_	Physicians Memor	6. Sax	spita		In yrs. last bir	thday)	If Undar	l Yaar	La P.		8 Data	of Birth		arles	polace (State or Fore
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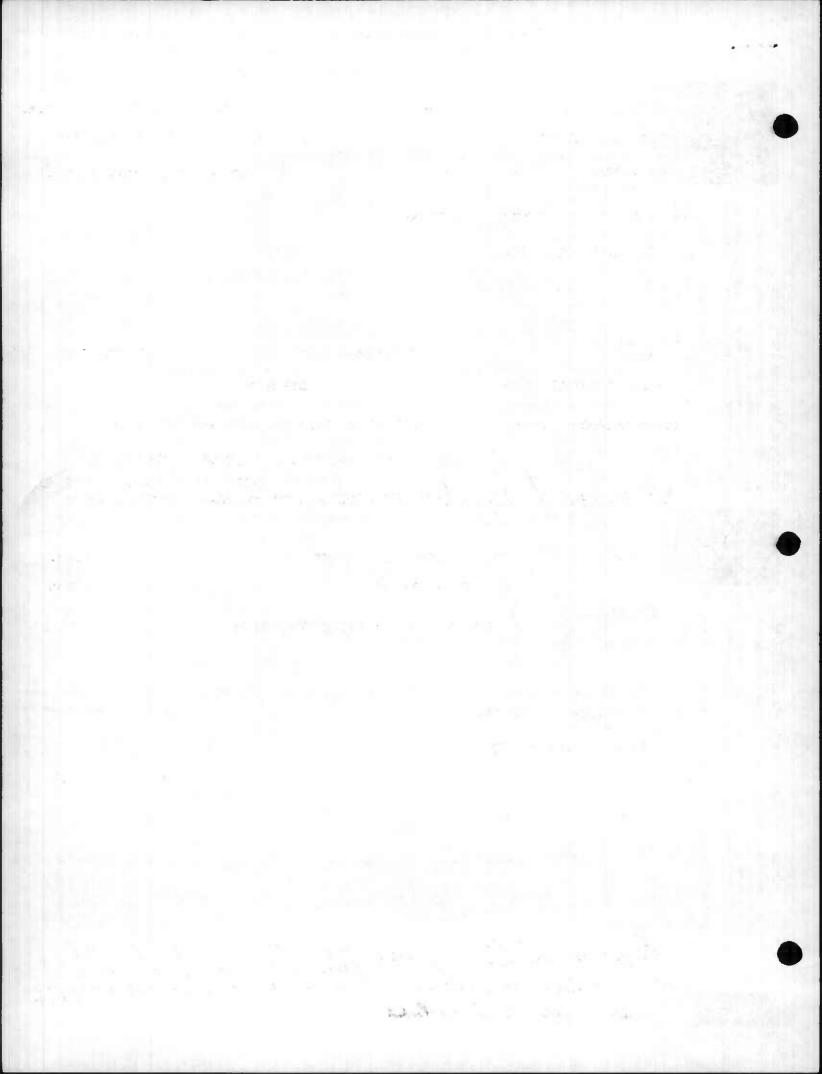
State of Maryland / Department of Health and Mental Hygiene

Physician					Ce		of Death	Re	eg. No.	U	4417
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/Medical		Helen E. Da							cy 8,19	98	10:15PM
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martic event, 1 To Be Co		Alonzo John	nson					Anna N	orris		
am si am si		Informant's Name/Relation	ship (Type, Print)		19b. Mailin	ng Address (Sti	reet and Number or R			Stata, Zip	Coda)
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other tr	20a.	Method of Disposition		20b. Pi	lace of Dispo	sition (Nama o	1		20c. Location -		
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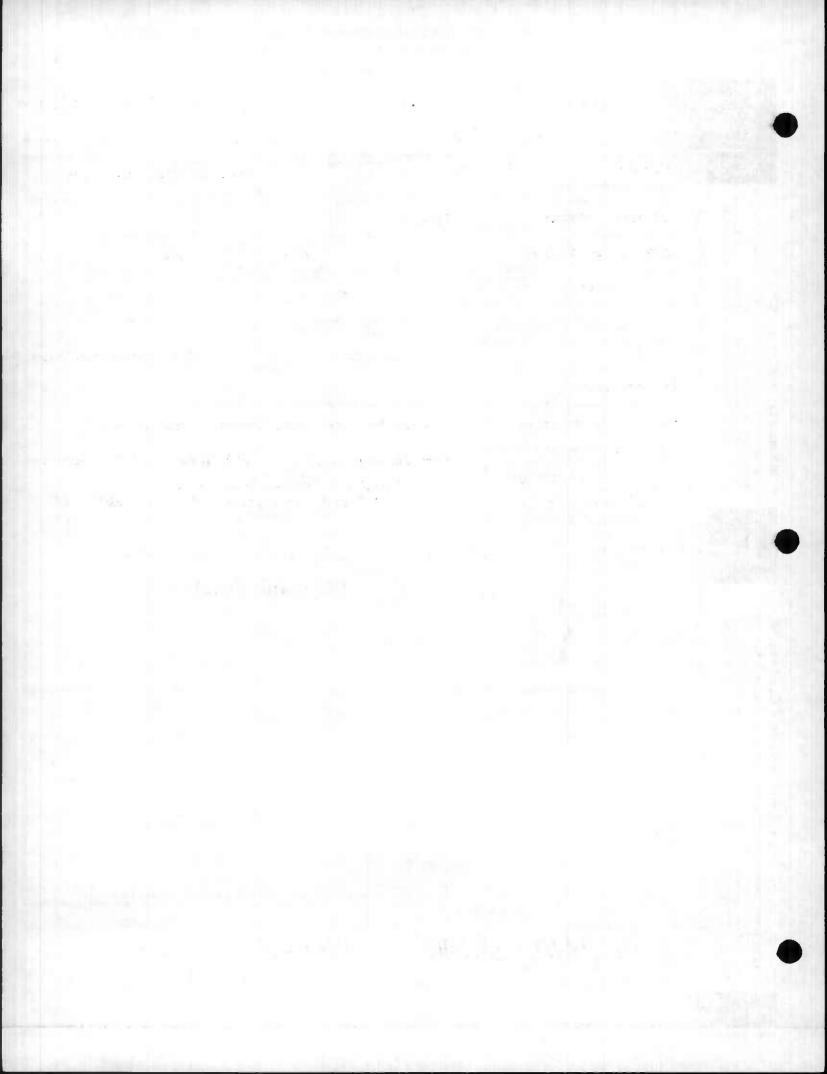
		Decedent's Nama (First, Middle, Las	r)		Cer	tificate	of L)eath	2. Data of Dea	eg. No.	UZ	3. Time of Deat
Physici		ANGELA MAI		DODE	v				January	Day	Year R	4:57 p.
/Medic Examin		4a. Facility Name (If not institution, give 3709 Stone Clif	street and number)	DORE	Y		41	o. City, Town, or L	ocation of Death	4c. County	of Death	RGE'S
Funeral Director		377-04-7932	7. Ag	e (în yrs. le 29	est birthday) Yrs.	If Under 1 Y	aar ays	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day APR . 10,		9. Birthple	ace (State of Fore
r 28a-f show	or	Usual Residence of Decedent 10a. State 10b. County MARYLAND PRINCE G	EORGE'S		, Town or Loc	ation					10	Od. Inside City Lim
ms 23s or 28s-f show	Funeral Director	10e. Street and Number 3709 STONE CLII				10f. Zip Co	de	20746	1	0g. Citizen of	What Count	ry?
al', or ite	by	11. Marital Status 1 Naver Married 2 Married 3 Widowad 4 Divorced	12. Was Decedent I Armed Forces? 1 Yas 2 If Yes, Give Yaar or Dates:			/as Dacedant Yas, specify		spanic Origin? (Sp n, Maxican, Puerto Specify:	pecify Yes or No- Rican, etc.)		ce - America ck, Whita, a y: BI	
natur	Completed	15. Decedent's Ed (Specify only highast grad Elementary/Secondery (0-12) 12th	loation (e completed) College (1-4or 5	5+)	(Give I life. D	ent's Usual O kind of work of O NOT use n	one di etired)	uning most of work	king	16b. Kind of B		ustry
nd Mentel Hygiene. merked other than imetic avent, the M	To Be C	17. Father's Name (First, Middle, Last) HYLAS NATHANIEL	DOREY					18. Mother's Nam				001111
end Men Is marke aumetic		19a. Informant's Name/Relationship (T	vpe, Print)		19b. Mailin	Address (S	reet a	nd Number or Rui	ral Route Number	, City or Town,	State, Zip	Code)
Heelth am 27 ther tr		DIANN DOLFORD/MO	THER	20h Pis	3709 ace of Dispos			FF RD. S	- T		20746	un Ctata
ent of l		Metrod of Disposition 1 □ Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,		Ca	metery, crem	atory or other	place		Date L-13-98	20c. Location -		
Depertment of Heelth Important: If Item 27 any Injury or other tronce.		21. Signature of Funarai Sarvice Licans	7 4	VA	22.	Name and A	ddress	of Facility MAF	RSHALL'S	FUNERA	L HOM	E OF MD
nysician Medical xaminer		23a. Part1. Entar the disease, or comp shock, or heart failure. List only of the composition of the composition resulting in death)	ne cause on each lin	ne.	Do not ente				or raspiratory arr	est,		Approximate Interval Between Onset and Death MINS.
	ner				as a consequ N FAIL						2	WEEKS
ettending physicien end for use es the buriel-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last	a ACQUI	Due to (or	as a consequ	penca of): DEFIC	IEN	ICY SYNDE	ROME			MONTHS
the ette	Physician/N	Part II. Other afgniffcant conditions co	ntributing to death bu	ut not resul	ting in the un	derlylng caus	e give	n in Part I.	23b. Did to	bacco uae co	ntribute to	the cause of dea
gned by be detec	by Phy	OROPHARYNGEAL	CANDIDIA	ASIS					1 🗆 Y	es 2X No	3 Prob	ably 4 ☐ Unkn
20 00	Completed	AIDS WASTING	SYNDROME						24a. Was a perfori		ava	re autopsy finding ilable prior to apletion of cause eath?
pe be		05.146				.,				s 2X No	10	Yes XXNo
s certif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	iospital:	nt 2 🗆 E	R/Outpatlent	3□ DOA	Othe	26. Place of Deat	th <i>(Check only on</i>		or (Coosih)	1
= 50		27. Menner of Death 1 Noturel 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		28b. Time of Injury		Injury Work 1 🗆 Y		28d. Describe ho			,
within 24 hours efter death. To the Funeral Director: After completely filled in by the funeral compl	Certification:	3 Suicide 6 Could not be determined	28e. Placa of Inju building, etc	ury - At hon c. (Specify)	ne, farm, stre	et, factory, of	lica		28f. Location (Si City or Town		er or Rural	Route Number,
24 hou Fune etely fi	edicai	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	alcian: To the best oner: On the basis of and menner sta	examination	ledge, death on and/or inve	occurred at the estigation, in	ne time ny opl	e, date and placa, nion, death occur	and due to the cared at the time, d	ause(s) and ma ate and placa,	anner as sta and due to	ated. the cause(s)
vithin To the somple	2	29b. Signature and title of certifier				29c. Li	cen <i>s</i> a	number	2	9d. Date signe	d (Month, E	Pay, Year)
7		Lushani	MI	20	MA	4	18.	365		1-	8 -	98
5)		30. Name and address of person who control of the state o	ompleted cause of de	eath (Item)	23a) (Type, P	rint) 54	117	LAND	FAMIL	HEA!	LTH (CTR.
	1'	- ICHINE WELL	MUNALAND	-/U'	ITNG	, 510		VILVER	TILLRI	1 FORE	=5711/	LLE ML



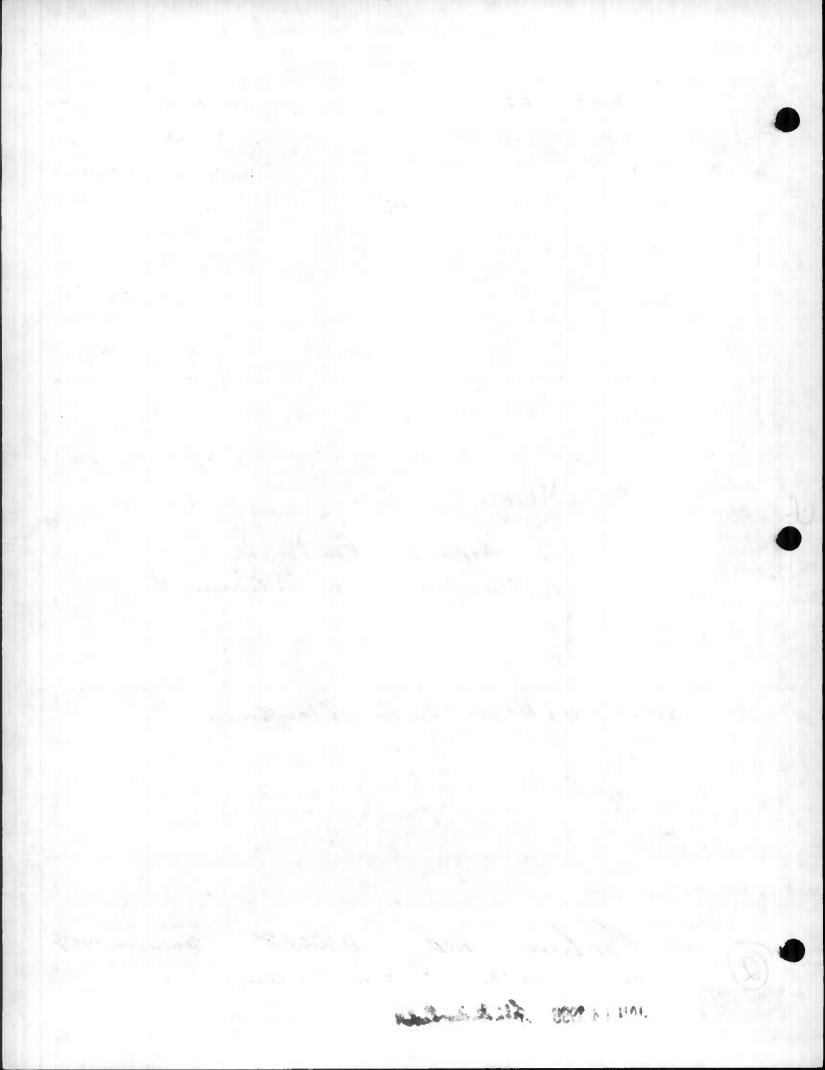
State of Maryland / Department of Health and Mental Hygiene 8

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The Funeral Director: After this certificate hes been signed by the attending physician and pletely filled in by the funeral director, page 2 should be detached for use as the buriel-trensit of	ledical Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate causa. Entar Underlying Causa (Disease or Injury thet initiated evants resulting in death) Last Pert II. Other eignificant conditions or axaminar? 1	Dua l C. Dua l d. Dua l d. Hospital: 1 Inpatlant 28e. Data of Injury (Month, Day Yea 28a. Place of Injury - building, atc. (Sp	to (or es e consecto to (or as e consecto to (or as e consecto to (or as a consecto) to (or as a consecto to (or as a consecto to (or as a consecto))).	quence of): Inderlying causa git Renard 1 3 DOA Ott 28c. Inju Wo M 1 real, factory, offica th occurred at that it vastigetion, in my of	26. Placa of Diner: 26. Placa of Diner: 42 Nursing ry at rk? 1 Yas 2 No	23b. Did 1	tobacco use co Yes 2 No an autopsy rmed? Yas 2 No ona) dance 6 □Oth now injury occur Streat and Numb vn, State) causa(s) and ma deta and plece,	anar (Specify) anar (Specify) anar es steteend dua to the	he cause of de bly 4 Unkr a autopsy findin abla prior to eletion of causa eth? Yas 2 No Route Number, ed. ha causa(s)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death William January 6, 1998 **Physician** 7:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 6820 Standish Drive Landover Hills Prince Georges 8. Date of Birth (Month Day, Year) 1931 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2□ F 220-28-1590 66 Virginia Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ¥ Yes 2 □ No Director PG Landover Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6820 Standish Drive 20784 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygione. Important: If Item 27 is marked other than "natural", or Ite any finury or other traumatic event, I'm Medical Experiments I □XYes 2 □ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: Black PV 3 Widowed 4 Divorced Year or Dates Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 11th Carpenter Local 132 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 William Eure Rebecca Smith 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine M. Eure- Wife 6820 Standish Dr., Landover Hills, MD 20784 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-12 Fort Lincoln Cemetery Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 4217 9th Street N W Washington, DC 20011 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Mach 20 months Examiner Physician/Medical Examiner and order use es the burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760, The law requires that the death certificete be Due to (or es e consequence of) P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records, P 24b. Were autopsy findings available prior to completion of ceuse of death? Completed director, page 2 should 24a. Was an autopsy performed? 2 NO NO 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manger of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Injury at Work? After 5 Pending Investigation s efter death. 1 ☐ Yes 2 ☐ No the 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) lin by 4 Homicide Hospital 24 hours 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

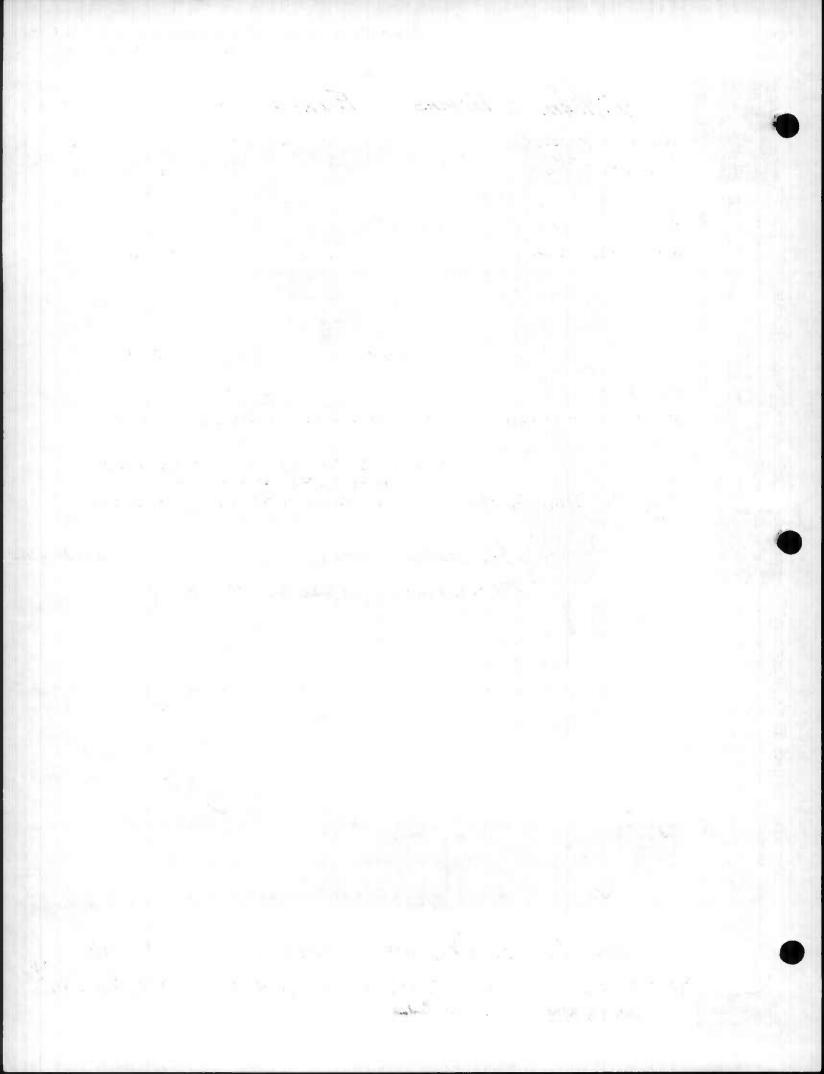
Year-Kwon H. Young, M.D., 7307 Baltimore Ave. # 111, College Park, MD

JAN 15 1998

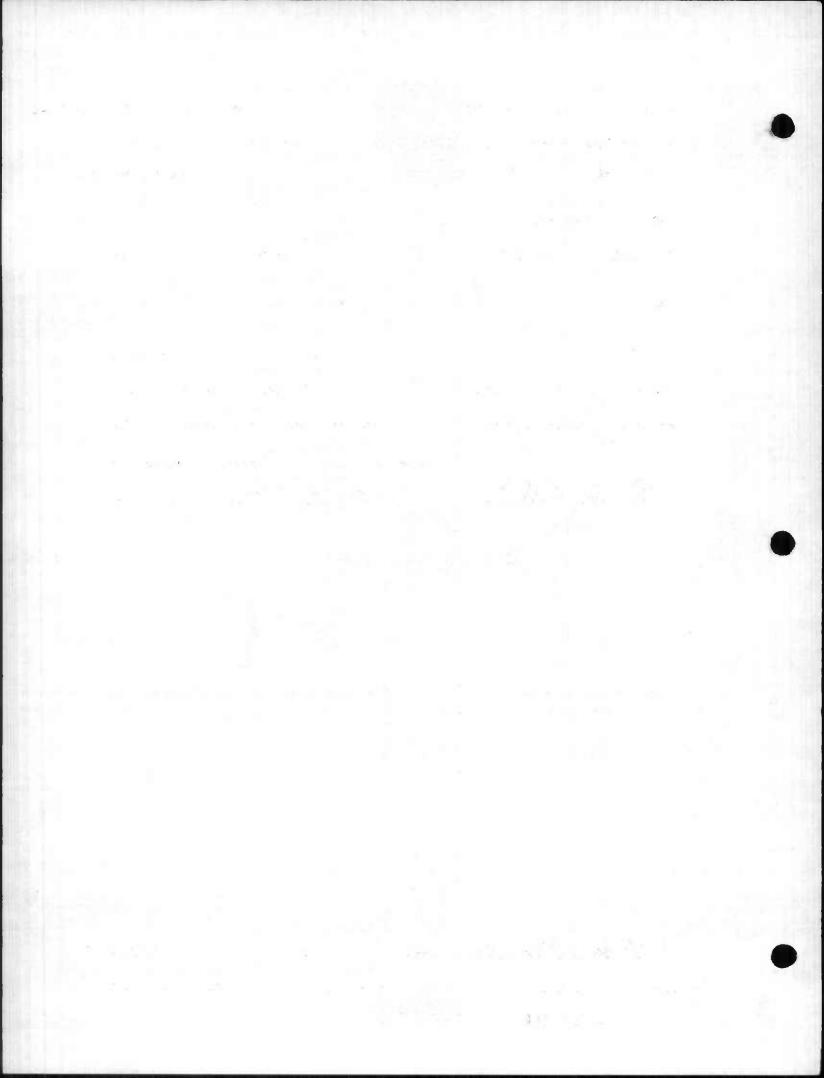
JAN 15 1998 29b. Signeture and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 16 Rev 6/95

State



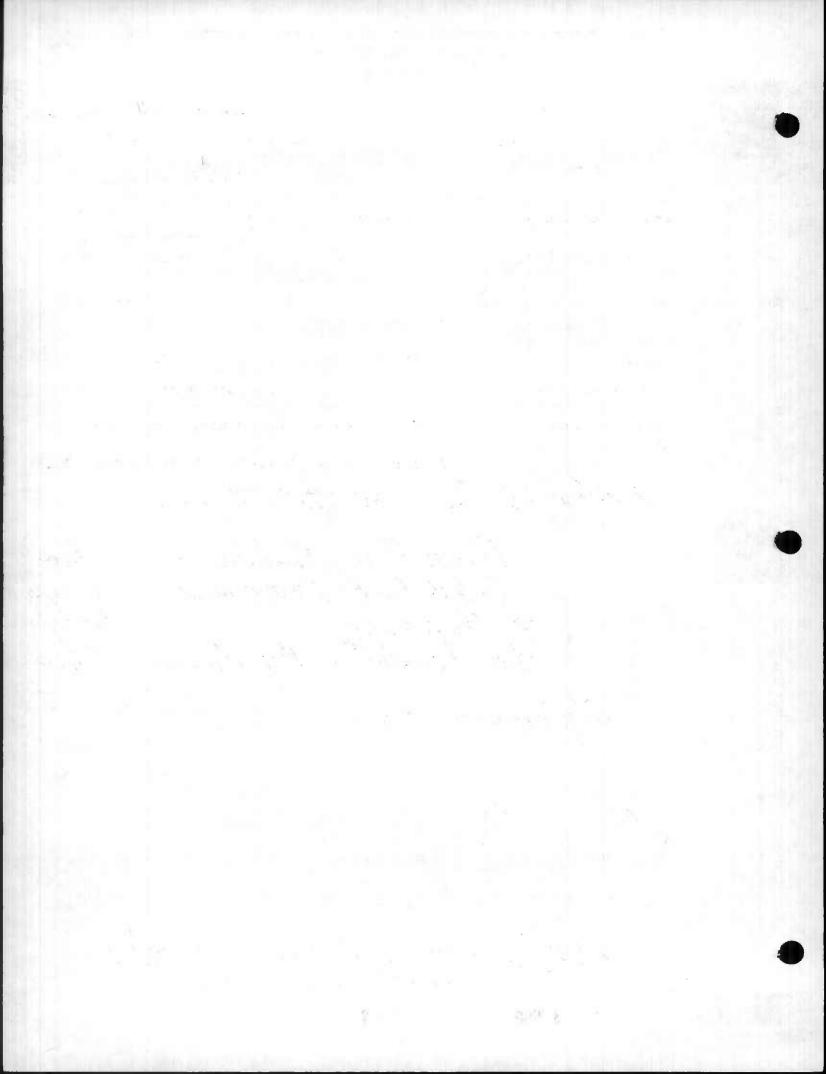
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	Physic /Medi		1. Decedent'a Nama Alice	(First, Middla, Las Marie	FRIEN	D			2. Data of De Month Januar	Day	Yaar 998	3. Tima of Death 1:25 AM
	Exami		4a. Facility Nama (If n	ot institution, give	a street and number,)		4b. City, Town, or L	ocation of Deat	4c. County	of Death	
9			Dennett H	Road Man	or Nursin	g Home		0akland		Gar	rett	
	Funeral		5. Social Sacurity Nur	mber 6. S	ax 7. A	ga (In yrs. last bir	hday) If Undar 1 Yaa	r If Undar 24 Hrs.	8. Data of Bir	th		laca (Stata or Foraign
ш	Director		214-42-06	666	□M 2FF	56	Yrs. Months Days	Hours Min.	Dec. 1		Mary	
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	show		10a. Stata	10b. County		10c. City, Town	or Location				10	Od. insida City Limits
	Ma	Director	MD	Garr	ett		Oakland					1 Yas 2 □ No
	r 28	5	10e. Street and Numb	per			10f. Zip Coda			10g. Citizan of	What Count	try?
	3a o	0	825 High	St., Ap	t. 205			21550			USA	
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020	filed within 72 hours efter deeth with the Maryland Hyglene. ther than "natural", or flerns 23a or 28a-f show int, the Medical Examiner must be notified at	by Funeral	1 Nevar Married		Armed Forcas' 1 ☐ Yas 2 ☑ If Yas, Giva Yaar or Datas:		If Yas, specify Cu 1 ☐ Yas 2 ☑ No		o Rican, atc.)	Specifi	ck, Whita, a v: Wh	ite
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D	be filed itel Hyg d other event,		17. Fathar's Nama (F	irst, Middia, Last)			THE DE D	18. Mothar's Nam	na (First, Middla			
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ī	s 1 end 2 should f Health and Mer tem 27 le marks other treumetic	-	19a. Informant's Nam				Malling Addrass (Stree					Code)
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9	of Health Item 27 I		20a. Mathod of Dispos		baughter	20b. Place of	Disposition (Nama of		Data Data	20c. Location		wn. Stata
0	Peges nent of int: If Its iry or o		1 N Burial 2 □	Cramation 3 🗆	Ramoval from Stata		y, crematory or othar pl					, 5.2.2
=	rtani njun		4 Donation 5		1	Gler	dale Cemet		1/19/98	Swanton	, MD	
Baltimore,	permit. Peges Department of Important: If It any Injury or o		21. Signature of Funa	De A	Deux			Funeral Ho cond St.,		MD 2	1550	
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	Physician /Medical Examiner		Immediata Causa (Fidisaasa or condition rasulting In daath)	nal	Brea						1	Onsat and Death / year
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oʻ	icate be executed physician end s the burial-transit	Examine	Sequentially list cond if any, laading to imm cause. Enter Undarly Cause (Disaasa or In)	itions, adiata	b. —	Dua to (or as a o	onsequance of):					
c 68760,		Medical	Cause (Disaasa or In) that initiated evants rasulting in death) La		С	Dua to (or as a c	onsequance of):					
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	he a	Sic	Part II. Other significa	ant conditions co	ontributing to death b	out not rasulting in	tha undarlying ceusa g	ivan in Part I.	23b. Dld	tobacco use co	ntribute to	the cause of death?
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Viita	Icien: The certificate rector, pag	Be C	25. Was cesa rafarred	d to medicel				28. Place of Dea			1	11202
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on of	D 9 5		27. Mannar of Death	5 Panding invastigation	28a. Data of Inju	ıry 28b. T	lma of 28c. Injury			how Injury occur		/
=	いままに	Certification:		8 Could not be datarmined	28a. Place of in	jury - At homa, fai c. (Spacify)	m, straat, factory, office	9	28f. Location (City or To	Streat and Numb wn, Stata)	er or Rural	Routa Number,
	To the Hospital or within 24 hours effer To the Funeral Dir completely filled in	edical (29a. Certifier 1 (Check only one) 2	Certifying Phy Medical Exam	vsician: To the best iner: On the bests o and mannar st	axamination and	daath occurred at that	time, data and place, opinion, daath occur	and dua to tha	cause(s) and madata and place,	anner as sta and dua to	ated. tha ceuse(s)
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	Cha	1	Dr. P. Da 31. Data filed (Month,		32. Registr	ar's Signature	Acres Dri	ve, Oakla	nd, Mar	yland 2	21550	
	Sta Registr				998	Marken	Carlet					



State of Maryland / Department of Health and Mental Hygiene 98

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Month **Physician** BERNADINE M. FRANCIS 9 1998 4c. County of Deeth 0020 A.M. /Medical 4b. City, Town, or Location of Death 4e. Fecility Neme (If not institution, give street and number) Examiner CUMBERLAND ALLEGANY SACRED HEART HOSPITAL If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) **Funeral** 1 M 2 W Months Devs 84 Yrs. 217-10-5957 Director Sept 20 1913West Virginia Usual Residenca of Decadent 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 XYes 2 No Md. Allegany Westernport 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 23a or 526 Maryland Ave. 21562 United States death Funeral or Herna 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours efter 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White A 3 Widowed 4 □ Divorced natural', Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Unknown 17. Fether's Neme (First, Middle, Last) Homemaker permit. Pages 1 end 2 should be filled. Department of Health end Mental Hygis Important: if Item 27 is marked other any injury or other traumatic event, if Home 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Frank Daniels Flossie Ours 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Daniels Furnace St. Lonaconing, Md.21539 20e. Method of Disnosition 20b. Place of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Philos Cemetery 1-12-98 Westernport, Md. 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Boal Funeral Home 111 Church St. Westernport, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) **Examiner** Physician/Medical Examiner un The law requires that the death certificete be executed physician and sthe buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Box 68760, thet initieted events resulting in deeth) Lest ettending | P.O. Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert 23b. Did tobacco use contribute to the cause of death? signed by the 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Records, þ page 2 should b 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy certificate hes 2 NO 1 ☐ Yes 2 No 1 T Ves Division of Vital tal or Attending Physician: The offer deeth.

In Director: After this certificated in by the funeral director, po 25. Was case referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 Naturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funeral Di completely filled in Hoepital 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) and manner stated. Medical (Check only one) To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme end eddress of p krnport M.D. Main 32. Registrer's Signeture 31. Date filed (Month, Day, Yeer) State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) **Physician** Richard Green Farrow January 10, 1998 7:05 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1X M 2□ F 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** Months Yrs. Director 188-32-3790 84 Jan 25, 1913 Pennsylvania Usual Rasidenca of Daceden the Marylend 10a State 10b. Counts 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Madical Examinat must be not fred 1 X Yas 2 □ No Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1209 Brantford 20904 USA 1.2 should be filed within 72 hours efter death in and Mental Hygiene. Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. 1 Never Married 2F Married 1 XYes 2 No If Yes, Give Year or Dates: Maryland 21215-0020 1 Yes 2 No Specify Specify: þ 3 ☐ Wildowad 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Pennsylvania Dept. al Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) of Welfare 5+Deputy Secretary 18. Mothar's Name (First, Middle, Maiden Sumama) 17. Father's Neme (First, Middle, Last) Be Marquerite Shoener Daniel R.G. Farrow, Sr. 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nama/Reletionship (Type, Print) permit. Peges 1 end 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum 1209 Brantford, Silver Spring, Maryland 20904 Daniel Farrow/son Baltimore, 20b. Placa of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 💆 Removal from State 1/17/98 Shamokin, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) Shamokin Cemetery 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature & Funeral Servica Moanses 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximata interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in death) Examiner Examiner physicien end the buriel-transit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last atherosclero Box 68760 Physician/Medical 88 USB 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? P.O. the signed by t coagulation with Coumaden 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? coronary astery disease 24a. Was an autopsy performed? Completed certificate has 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, To 1 ☐ Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerel 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Aftert 5 Pending investigation 1 X Natural or Attending after death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 Homicide an 24 hou. Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical To the Hosp within 24 ho To the Fune completely fi 29b. Signatury and title of certified 29c. Licansa number 29d. Date signed (Mooth, Day, Year) al 15 30. Name and address of person completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Data filed (Month, Dey, Year)

JAN 1 2 1998

Povar

32. Registrar's Signature

8700 Georgia Avenue, Silver Spring, Maryland 20910

Mary Vol. 30 Art of the property of the proper الإلام والقدار فالمستوار اللحاق

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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/Medical xaminer	4a Fecility Name (If I	not institution, give	street and number)		4b. City, Town,	or Location of Dea		
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neral ector	5. Social Security Number 161-09-4 Usuel Residence of E	14418 6. Se		n yrs. lest birthday)	If Under 1 Year If Under 24 I	fin. 8. Date of B (Month, I	irth 9. Dey, Year) 9. 3, 1917	Birthplece (State or Forei Country)
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ecto	10e. Street end Numi	LECIL		ELKTO	10f. Zip Code		10g. Citizen of Whe	
ust be notified at	TEZO 1.1+	11/1/1	110:00		7/07/		Tog. Citizen of Whe	n Country?
eral	11. Marital Status	TITEMAL	12. Was Decedent Eve	r in U.S. 13. Wa	as Decedent of Hispenic Origin?	(Specify Yes or N	14. Race -	American Indian,
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Injury o		5 Other (Specify		RA Feli	US INC.	1/13/98	W. Ches	ster PA.
any Inju	21. Signature of Fund	eral Service Licen	900 M	22.1	Name and Address of Facility	5+ 01	Gee Fune	ral Home
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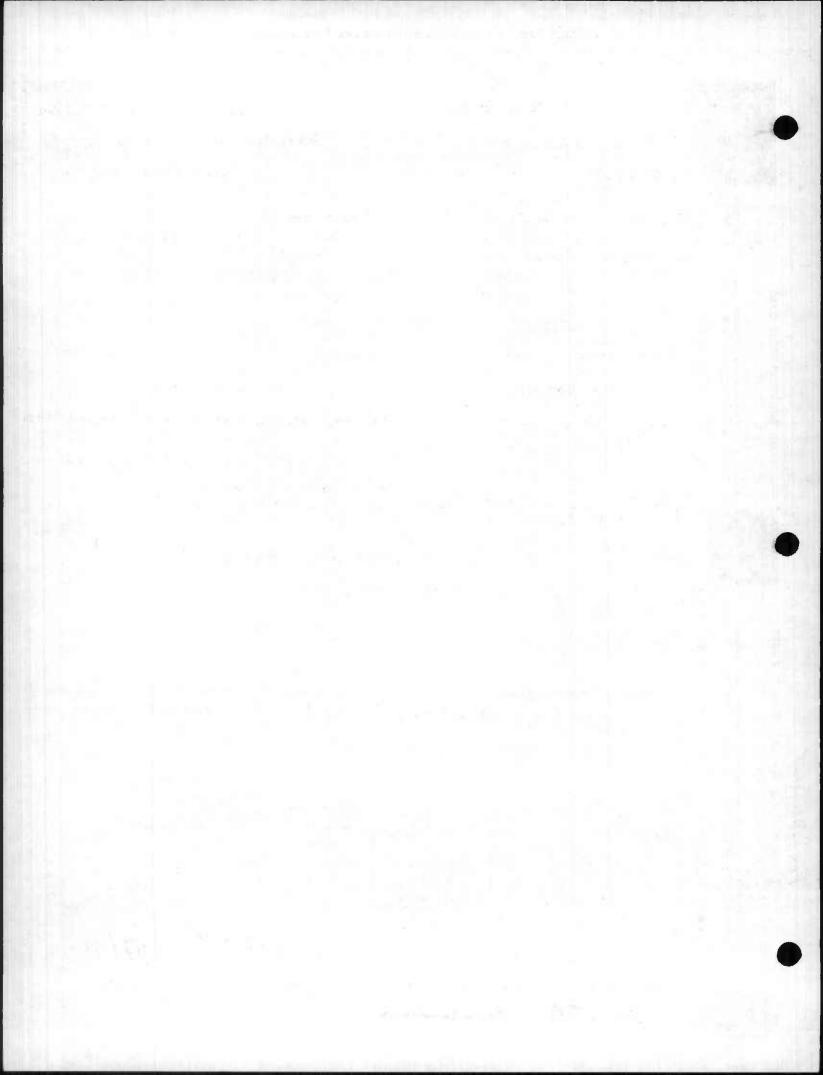
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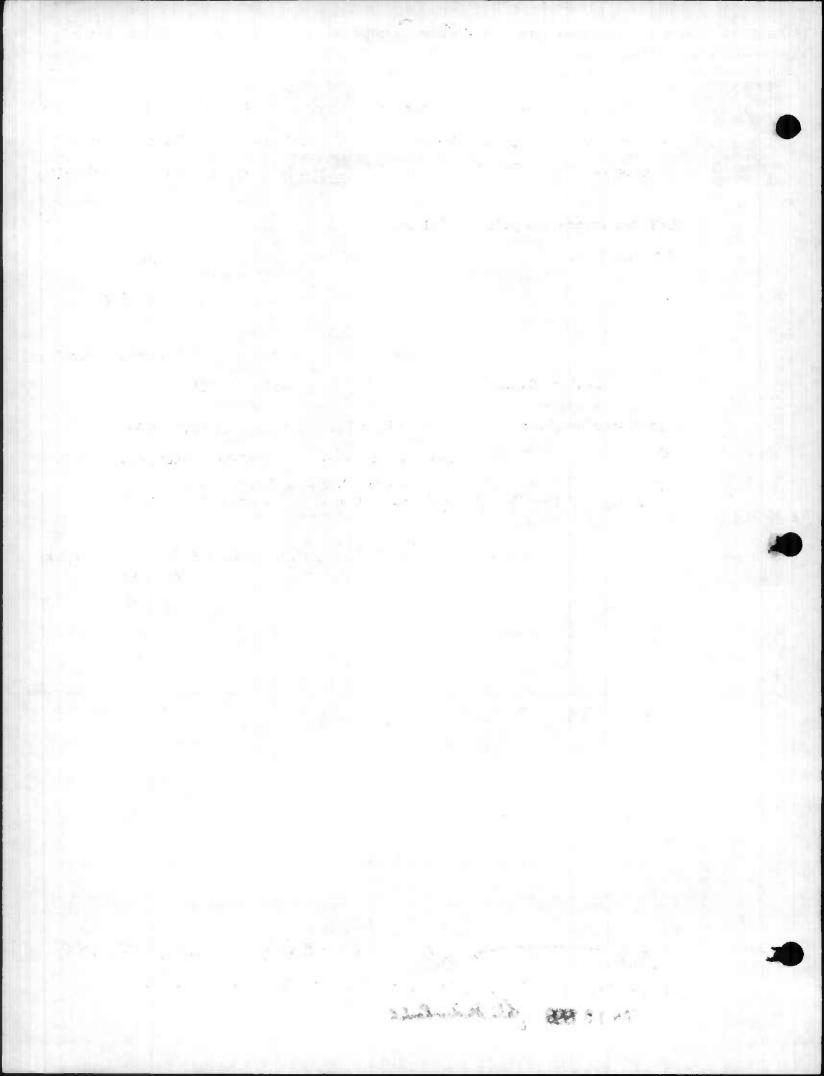
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State of Maryland / Department of Health and Mental Hygiene U 2 2 8 8

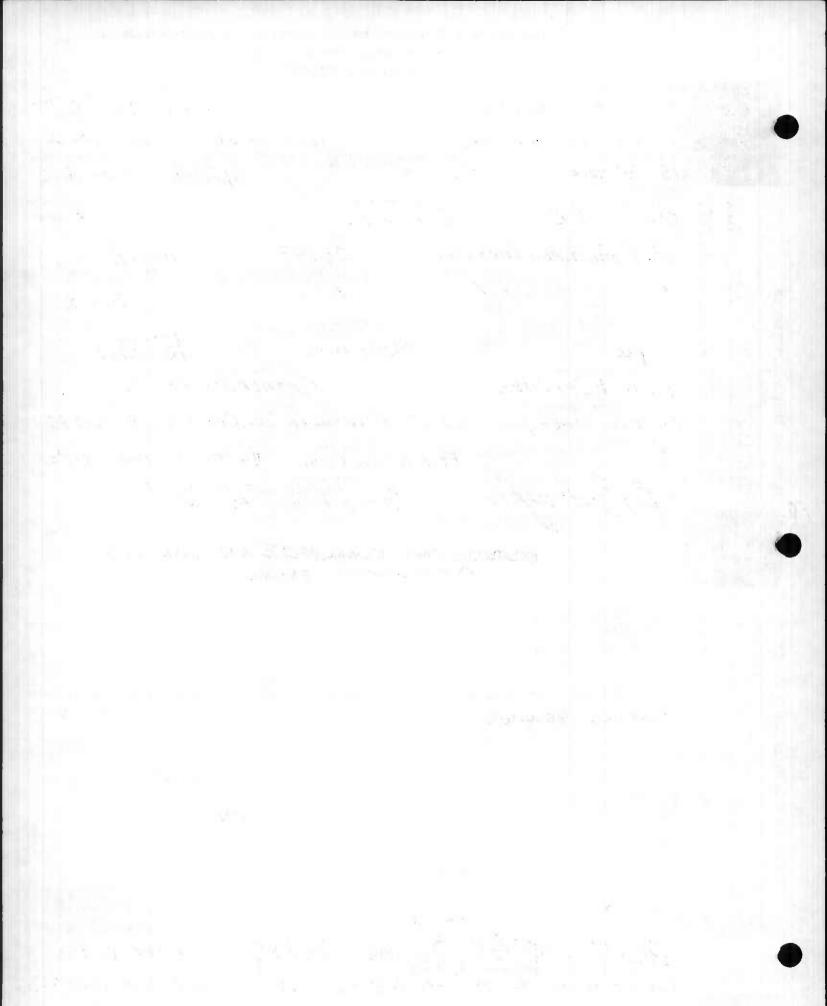
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	era	11. Maritei Status		Decedent Ever In	U,S. 13.	Wes Decadent of	Hispenic Origin? (Sp ben, Mexicen, Puerto	pecify Yes or No-		e - American Ir	ndien,
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Physician /Medical	-	Bessie	Mae		Farm	er					9, 199		11:20 A.M
Examiner	_	4e. Fecility Neme (If not Institution, give	street and numb	er)				4b. City, To	wn, or Loc	cation of Deeth	4c. Coun	ty of Deeth	
		Southern Marylan	d Hospit	al Cer	nter			Cli	nton		Prince	e Geo:	rge's
Funeral Director		5. Social Security Number 6. Sec. 164–56–5312 Usual Residence of Decedent	ex 7. □ M 2∑ F	Age (In yrs. 77	last birthday Yrs.) If Unde Months	Deys	If Under Hours	Min.	8. Date of Bird (Month, Da May 1,	h y, _{Year)} 1920	9. Birthi Cour South	olece (State or Foreign ntry) Carolina
death with the Maryland rms 23a or 28a-f show r must be notified at		10a. State 10b. County Maryland Prince	Coorsola		y, Town or L								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
or 28s	Sire.	10e. Street end Number	George S		Suitla.		Code				10g. Citizen of	What Cou	ntry?
23a Land	2	6010 Ladd Rd.					2074	6			U.S	S.A.	
ors efter	2	11. Meritel Stetus 1 Never Married 2 Married 3 N Widowed 4 Divorcad	12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Yeer or Date	s? XI No	S. 13.	Was Dece If Yes, spe 1 Yes			gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		ice - Americeck, White,	etc.
n 72 hours natural', social Ex	5	15. Decedent's Ed (Specify only highest grad			16e. Deca	adent's Usu	el Occup	etion duning mos	of workin		16b. Kind of I	Business/in	dustry
han han	HOLE.	Elementery/Secondary (0-12)	College (1-4	or 5+)	life.	rses a	se retired	d) mos	or workin		Desir and to	. D .	NT .
C A Pagi	3	17. Fether's Neme (First, Middle, Last)			lvu.	1368	110	19 Mothe	r'e Nomo		Maiden Suma		Nursing
gless I ent & should be med with a hygie to or other traumatic event, in To Be Co	ă	Kisler	Shider					Que			leton	me)	
d Men marke	-				405 14-11		(0)						
trau trau		19a. Informent's Name/Relationship (7									ar, City or Town		Code)
Healt Ther	-	Joyce Lyons/Daugl 20a. Method of Disposition	iter	20h P	6010	Ladd	Rd.	Suit	land,	Mary 1	and 207	46	num Ctata
or o	1	1 Deuriel 2 ☐ Cremation 3 ☐		(0	leca of Disp emetery, cre				1/2				
tant:	-	4 Donation 5 Dother (Specify		Bur	r Hil						Cottage	eville	e, S.C.
permit. Peges 1 and 2 Department of Health of Important: if item 27 is any injury or other tra once.		21. Signature of Funeral Service Licens	TY C	las						eral Ho Oxon Hi	me 11, Md.	. 2074	15
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)	a ANE	LLOS Due to (o	r as a conse	COTTO		CARD	(8)	ASCU	2 AN	ACE	Onset end Death 4 EASLS
an end inel-transit	Lyan	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	b	Due to (o	r as a conse	quence of)							
eem connicate be executed etherding physician and for use as the buriel-transit clan/Medical Examir	Na Car	Ceuse (Diseese or injury thet Initiated events resulting in death) Last	d	Due to (or	r es e conse	quence of):							
d by the ettence detence detected for us	5												
00	2	Part II. Other significant conditions co								23b. Did 1	obacco use c	ontribute t	the cause of death?
a g	. A	MULTIPLE	Pecc	BIT	S	Ucc	51	1		10	Yes 2 No	3 □ Pro	bably 4 ☐ Unknown
2 shoul	ישופופו										an autopsy med?	ev	ere eutopsy findings eilable prior to mpletion of cause deeth?
ate h	5									101	res 2 No	10	☐ Yes 2☐ No
is certificate has be director, page 2 s		25. Wes case referred to medical exeminer?						26. Plece	of Deeth	(Check only o	ne)		
	0	1 ☐ Yes 2 No	Hospitel:	atient 2	ER/Outpatle	nt 3□ D	Oth Oth	er: 4 Nu	rsing Horr	ne 5 Resid	denca 6 □Oi	her (Specia	y)
£ 8		27. Menner of Deeth	28e. Dete of I	jury Dey Year)	28b. Time of Injury		28c. Injur Wor			8d. Describe h	now injury occu	rred	
For After	5	1 Naturel 5 ☐ Pending investigation	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At ho building, etc. (Specify						M 1 ☐ Yes 2 ☐ No home, ferm, street, fectory, offica 28f. Loca				
s efter deeth. In Director: Afte ed in by the fun Certification	- Common of the common of the	2 Accident investigation 3 Suicide 6 Could not be	28e. Flece of	Injury - At ho etc. (Specify	ome, ferm, st		y, offica		2	8f. Location (S City or Tox	Street and Num vn, State)	ber or Rura	al Route Number,
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ithin 24 hours efter deeth. o the Funeral Director: Afte completely filled in by the fun. Medical Certification	redical cer illication	2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only 2 Accident 6 Could not be determined	building,	etc. (Specify st of my know of examinet	v) wledge, deat	th occurred	et the tin	ne, date en plnion, deel	d plece, e	City or Tow nd due to the id et the time,	m, State) cause(s) end m dete and place	nenner es s , and due to	teted. the cause(s)
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To the Hospital or Attending within 24 hours ster deads within 24 hours ster deads completely filled in by the fune Medical Certification	medical certification	2 Accident 3 Suicide 4 Homicide 299. Certifier (Check only one)	reician: To the be iner: On the basis end manner	efc. (Specify st of my know of examinel stated.	wledge, deat wledge, deat dion end/or Ir	treet, fector th occurred evestigation 29	et the time, in my o	plnion, deel	d plece, eith occurre	City or Town	cause(s) end midete and place 29d. Date sign	nenner es s , and due to ed (Month,	teted. the cause(s)



			•	Certificate o	f Death		Reg. No.	3 05530	
Physic	an	1. Decedant's Nama (First, Middla, Las				2. Data of Do	eath POUN	Yaar 09:00 AM	
/Medi			LETCHER			JANUA	RY 12,1	118 FALLID	
) Exami	ner	4a. Facility Neme (If not institution, give			4b. City, Town, or L				
			AND PARK		CAPITOL H			CE GEORGES	
Funeral Director	F	5. Social Sacurity Number 6. S 2/5 - 36 - 4666 1 Usual Rasidance of Decedent	7. Age (In yrs. le	Yrs. Months Day		8. Data of Bi	rth ay, Year) 0/39	9. Birthplaca (State or Foreign Gountry) WASH, D, C,	
and w		10a. Stata 10b. County	10c. City	, Town or Location				10d. Inside City Limits	
the Marylar 28a-f show	ector	MD. P.G		AP. HGTS.				18 Yes 2 □ No	
ath with I	Funeral Director		NO PARK DR.		0743		10g. Citizan of V	S. A.	
5-0020 72 hours effer death with the Maryland natural; or items 23s or 28s-f show ofcel Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowad 4 Divorced	12. Was Decedant Evar in U,S Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Datas:	13. Was Decedant of If Yas, specify Co	f Hispanic Origin? (Spuban, Maxicen, Puerto o Specify:	ecify Yas or N Rican, atc.)	Specify	e - Amarican Indian, ck, Whita, atc. BLACK	
72 hour	eted	15. Decedant's Ed (Spacify only highast gra	ucetion	16a. Dacedant's Usual Occ	upation	ina		usinass/industry	
S 5 3	Completed	Elamantary/Secondary (0-12)	Collage (1-4or 5+)	(Giva kind of work dor lifa. DO NOT usa rati		rg	7 // -	STEY	
d 212 filed with Hygiena. fther than	ပိ	17. Fether's Nama (First, Middla, Last)		11/2011/1	18. Mothar's Nam	a /First Middle			
ed al la po	To Be	JOHN FLET	CHER				BROOM		
Md 2 and 2 a		19a. Informant's Name/Relationship (1) SEPH FLETCHE	R BROTHER		ND PK. DR	ral Routa Numb	per, City or Town, HG75.,,	State, Zip Code) MD, 20743	
altimore, mit. Pages 1 en pertent of Haal portant: If Itam 2 y Injury or other 24.		20a. Mathed of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Spacify	Ramoval from Stata	ace of Disposition (Nama of matary, crematory or other p	Em.	16 /98	BRENTO	City or Town, State WOOD, MD.	
Ball permit. Depart import any inj		21. Signature of Funeral Service Ligan	weld-	H.S.WA	SHINGTON IRROUGHS	+ SONS	Co. , 11	vc.	
		23a. Part1. Enter the disease, or com- shock, or haart tailure. List only	cons thet caused the death.	. Do not enter the mode of d	ying, such as cardiac	or respiretory	errest,	Approximate	
Physician	1	Snock, or naart tallure. List only	causa on aach lina.					Interval Batween Onsat and Daath	
/Medical		Immediate Ceuse (Final	a HYERTENSIVE (ARDIO ASCULA	2 DISEASE	AND C	PILIPOULCE	REGIA	
Examiner		disaesa or condition rasulting in death)	a. 117/C/19/00/00	as a consequence of):	FAILUR	-	HI ON (O	RENDE	
	Jer		(OI	as a causequence on.	FAILUR				
60, be axecuted ician end burial-trensit	Examiner	Sequentially list conditions	b. Dua to (or	as a consequance of):					
O, an er an er		Sequantially list conditions, if any, leading to immediata ceuse. Enter Undarlying Cause (Diseasa or injury that Initiated avants							
68760, flicete be ax physician ss the burial	cai	Cause (Diseasa or injury that Initiated avants	C. Due to (or	as a consequance of):					
rtifice ng ph	Physician/Medical	resulting in daath) Last							
BOX aath cert attendin I for usa	an		d						
A dea	sici	Part II. Other significant conditions co	ntributing to death but not rasul	ting in the underlying ceuse	givan In Part I.	23b. Did	tobacco uae co	ntribute to the cause of death?	
at the de	Ph.	DIABETES ME	ELLITIZ			1 🗆	Yes 2 No	3 □ Probably 4 D Unknow	
as that igned to be detailed	by	VIMBOLOS MIC	- Ius					/	
Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be assecuted after death. Director: After this certificate has been signed by the attending physician end in by the tuneral director, page 2 should be detached for use as the burial-trensition.	Completed					24a. Was	s an autopsy ormed?	24b. Were autopsy findings eveilable prior to complation of cause of death?	
The law ata has page 2	Eo					10	Yas 2 No	1 ☐ Yes 2 ☐ No	
VITAL Indicater: The certificate	Be C	25. Was cesa rafarred to medical			26. Placa of Daal	h (Check only			
ysick is cen direct	To B	examinar? 1 √Yas 2 No	Hospital: 1 ☐ Inpatiant 2 ☐ E	R/Outpatient 3□ DOA	Mhan		idance 6 □Oth	as (Cnecity)	
Vision of Vita Attending Physician: or death. sector: After this certific by the funeral director,		27. Mahnar of Death	1	28b. Tima of 28c. In			how injury occur		
ding Figure After	tion	1 Natural 5 Panding 2 Accidant invastigation	(Month, Day Yaar)		/ork? □ Yas 2 □ No				
dear dear	Certification:	3 ☐ Sulcida 6 ☐ Could not be	28a. Place of Injury - At hon	na, farm, straat, factory, offic	e	No 28f. Location (Streat and Number or Rural Routa Number,			
Oiv or a affer Dire	ert	4 ☐ Homicida determined	building, atc. (Spacify))		City or To	wn, State)	,	
Divisio To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A complataly filled in by the for	edical C	29a. Cartifiar (Check only one) 1 Cartifying Phy	raiclan: To the best of my know inar: On the basis of axamination	ledge, death occurred at tha on and/or invastigation, in my	tima, data and piace, opinion, daath occur	and dua to tha	cause(s) and ma data and place.	anner as stated. and dua to tha ceusa(s)	
ithin of the symple	Mec	29b. Signetura and titla of certifiar	and manner steted	29c, I los	nse number		29d. Data signe	d (Month, Day, Year)	
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		21 Date filed (Month Day Year)	- lary	OU HOSPITAL	NAVE	CHEVA	my In	ALLANDIN 10 18	
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	charlett	·		· ·		
Registr	ar	JAN 1 4 199	Q Water to the same of the sam						



State of Maryland / Department of Health and Mental Hygiene 8 02291

							erti	ificate c	of L	Death			Reg. N	0.			
Physi /Med		1. Decedent's Name (First, M Vincent Th	iddle, La omas		nina							2. Dete of De Month Januar	De	ey 4, 1	Yeer 998	3. Time of Dea	
Exam		4e. Fecility Neme (If not instit	ution, giv	ve street end n	umber)				41	b. City, To	wn, or 1	Location of Dee		_	y of Deeth	T T T T	
		5011 Laguna	Roa	.d						Co11	ege	Park]	Prin	ce Ge	eorge's	
Funera	ı	5. Sociel Security Number		Sex 1⊠M 2□F	7. Age (In yrs. lest birtha	A	If Under 1 Ye		If Under Hours	24 Hrs. Min.	8. Date of Bi	rth ev. Year	.)	9. Birth	plece (Stete or For	reign
Directo	r -	578-56-6590		IMM ZLIF		54 Yrs			,,			June 2	, 19	43		ington,	
and w		Usuel Residence of Decedent 10e. Stete 10b. Con			1	Oc. City, Town o	r Loca	tion							1.	10d. Inside City Li	mite
f sho	0	Maryland Prin		Coorest		Co1100	. T	2 1-								1 X Yes 2 □	
the 128s	rect	10e. Street end Number	ice (George	S	Colleg	e r	10f. Zip Cod	le				10a C	itizen of	Whet Cou	ntn/?	
72 hours ettar death with the Maryland natural*, or items 23s or 28s-f show pical Examiner must be notified at	Funeral Director	5011 Laguna I	haos					2074						J.S.			
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eftar or ite		1 ☐ Never Married 2 ☑ I	Married	Armed F	2 X No						n, Puerti	o Rican, etc.)			ck, White,	etc.	
ours raft,	by	3 ☐ Widowed 4 ☐ Divor	ced	If Yes, G Year or I			11	JYes 2∭ 1	No	Specify:				Specil	y: Whi	ite	
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od within 7 giene. er than 'n	JQE.	Etementery/Secondary (0-1			(1-4or 5+)			nd of work do NOT use ref									
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d 2 should be file th and Mentel Hy 7 is marked othe traumatic event	Be	17. Fether's Neme (First, Mid			, .							ne (First, Middle	, Maide	n Sumer	ne)		
should nd Men marka umatic	2	Charles Ber	naro		nına	40h 14	- Ni	A dd (O)		Jan		Porter	- 0"	-	0		_
permit. Pagas 1 end 2 should be filed within Departmant of Health and Mentel Hygiene. Important: If item 27 ia marked other then ' any Injury or other traumatic event, the Me												iral Route Numb				•	
1 end Health em 27		Marilyn J. Fa	icen:	ina – w		20b. Pleca of Di	spositi	ion (Neme of	F		OII	ege Par			Land - Olty or To		
Pagas nant of I		1 Burial 2 □ Cremati			State			tory or other			t				,		
emit. Pagas 1 er Department of Hea mportant: If item iny Injury or other		4 Donetion 5 Othe	ion Licer			Fort Li		In Cer				1/19/98	Br	entw	rood,	Marylan	d
permit. Departments Imports any Inju		() J J J K	7	1	10	11-						ns Fune	ra1	Hom	e. P.	Α.	
-		Luly	Aer	auli	Ju	4	47:	39 Bal	ti	more	Ave	nue, Hy	atts	svil	lé, M	ID 20781	
	н	23a. Part1. Enter the distance shock, or heart failure.	List only	one cause on	each ane	g-death. Do not	enter	the mode of d	ayıng	, such es	cardiac	or respiretory e	errest,		1	Approximete Intervel Between Onset end Death	1
Physiciar /Medica	_	Immediate Cause (Final		۸ -	,				-	,	-0	-1. •				11	
Examine		disease or condition resulting in deeth)		. A Gu	re	e to (or ea e con	Co	ardi	al	11	2 70	arction				1 hour	L
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outed	Examiner	Sequentially list conditions		b. Cor	Du	e to for es e con	seque		0	200	234	٤				10 9/3	-
ficata be exection and physician are the buriel-to		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	J	14.		+0.		•								10 V25	
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v require been si should	Completed											24a. Wes	en euto	psy	ev	ere eutopsy findin ellable prior to	-
a law has b	nple														of	mpletion of cause deeth?	
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Physician: The law requires the this certificate has been signeral director, page 2 should be to	70	1 Yes 2 No			Inpatient	2 ER/Outpe		3LI DON	Othe	4 140	rsing H	ome 5 Res				у)	
f or Attending F after death. Director: After I in by the funer	Certification:	27. Menner of Deeth			of injury oth, Dey Yo	ear) 28b. Time Injur			Vork			28d. Describe	how inju	iry occui	red		
Attending ir death. ector: Aftai by the fune	Icat	3 ☐ Suicide 6 ☐ Co	estigation ald not be	e on Die	o of Inium	At home form	0450.04			'es 2 □ i	NO	39f Location	Stroot o	nd Numl	hor or Bur	al Pouto Number	
or Attendate after death Director:	ertif	determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, Stete)							
pital ours ours filled		29a. Certifier Certi	lvina Ph	velcian: To the	a host of m	v knowledge de	eth or	ocurred at the	a time	a date en	d ptece	and due to the	cause/s	e) and m	onner ec c	totad	-
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only one)	cai Exan	niner: On the b	esis of exi oner steted	ny knowledge, de eminetion end/oi 1.	Inves	tigation, in m	y opi	Inion, deal	th occur	rred et the time,	date en	d place,	end due to	the ceuse(s)	
o the	Me	29b. Signafore end title of cer	ifier	U. G. Hildi	5(0(00			29c. Lice	ense	number			29d. Da	ate signe	ed (Month,	Dey, Year)	
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(1)		Paul Armstro						-	e.	#102) _ Т.	aure1.	Mars	71an	d 20	707	
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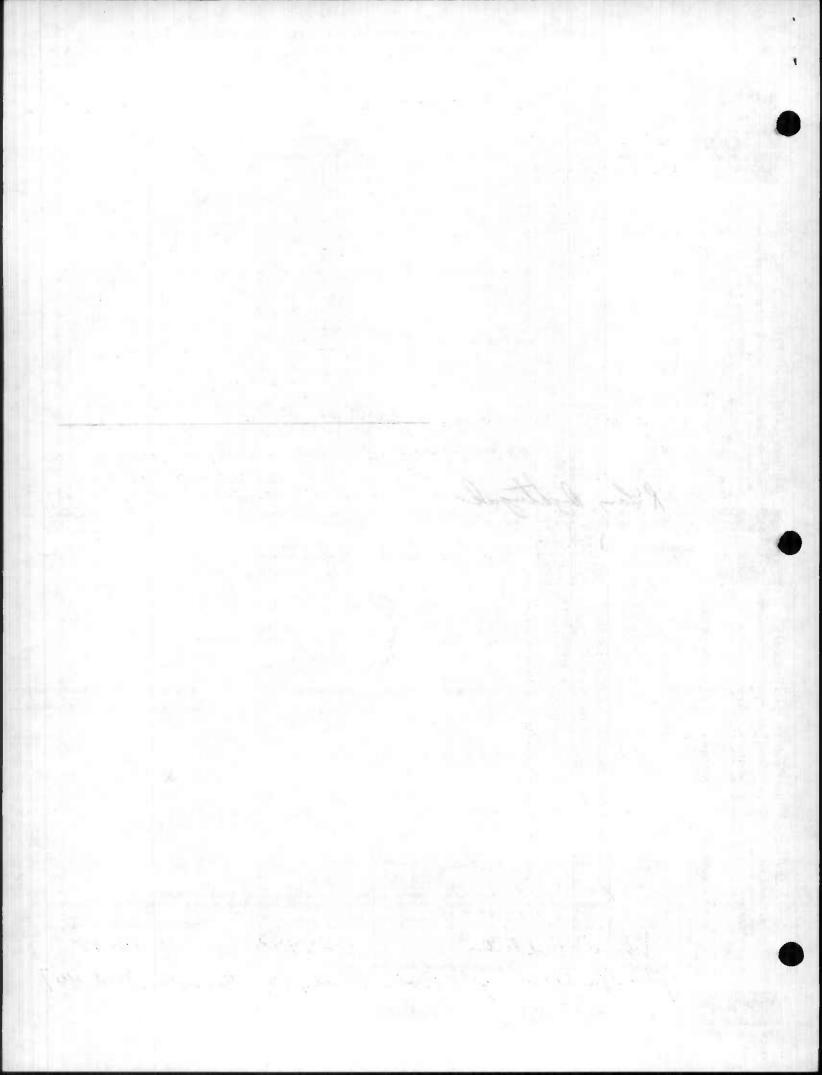
DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item #19b, per F.D. State of Maryland / Department of Health and Mental Hygiene () 1/20/98, Carroll County, wjl Certificate of Death 1. Decadant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** MINNIE GRACE FOGLE 14, 1998 JAN. 2:30 AM. /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Deeth Examiner WESTMINSTER NURSING HOME WESTMINSTER CARROLL If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Steta or Foraign Country) **Funeral** Months Days 1□ M 2☑ F 212-01-8642 Director 85 FEB. 12, 1912 MARYLAND Usual Rasidance ot Decadant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits event, the Medical Examiner must be notified at MD. CARROLL WESTMINSTER Director 1 X Yas 2 ☐ No 10a. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? ō 37 JOHN ST. Items 23a 21157 USA. death Funeral 12. Was Dacedant Ever in U,S. Armed Forcas? 11. Marital Status Was Decadant of Hispanic Origin? (Spacify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. filed within 72 hours efter 1 Naver Married 2 Marriad 1 ☐ Yas 2 No If Yes, Giva Yaar or Dates: Baltimore, Maryland 21215-0020 ò 1 Yas 2 No Completed by Specify: 3 ₩ Widowed 4 Divorcad WHITE "natural", 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education 16b. Kind ot Businass/Industry (Specify only highest grada complated) than Elementary/Secondary (0-12) College (1-4or 5+) 8 SEAMSTRESS MANUFACTURING Hygi other 17. Fether's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be Peges 1 end 2 should be finent of Health end Mentel I int: If Item 27 is marked of HOWARD BAIR MINNIE BELLE LITTLE 2 traumatic 19a. Intormant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
736 JOHAHN DR., WESTMINSTER, MD, 21158
756 JOHAHN DR., WESTMINSTER, MD, 2115 permit. Pages 1 and 2 s Department of Health er Important: if Item 27 is any Injury or other trau BRENDA WEBB DAUGHTER WESTMINSTER, MD. 20b. Piece of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Buriai 2 ☐ Cramation 3 ☐ Removal from Stata KRIDER"S CEMETERY 1/17/98 WESTMINSTER, MD. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Fecility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 Part 1. Entar the disassa, or complications hat caused the death. Do not anter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata Interval Batw Onsat and Death **Physician** /Medical Immadiata Causa (Finel disaase or condition rasulting in death) Examiner Examiner C The law requires that the death certificate be executed Sequantially list conditions, if eny, laading to immadiata cause. Entar Underlying Cause (Disaasa or injury that initiated avants rasulting in daath) Last Due to for as a consequence of: Box 68760, physician Physician/Medical the Due to (or as a consequence of): for use es signed by the e Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 70 3 ☐ Probably 4 ☐ Unknown þ 24b. Wara autopsy tindings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? page 2 2 No 1 ☐ Yas 2 ☐ No certificete Hospital or Attending Physician: director Be 25. Was casa refarred to medical 26. Place of Death (Check only ona) Other: 4MNursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 DOA this funeral 28c. Injury et Work? 27. Manner of Death 28a. Data of injury (Month, Day Year) Certification: 28b. Tima of 28d. Dascribe how injury occurred After 1 Natural 5 Pending invastigation death. 1 ☐ Yas 2 ☐ No 2 Accident i efter death I Diractor: / d in by the f 3 Suicida 6 Could not be 28a. Place of Injury - At homa, tarm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 Homicida To the Hospital or within 24 hours eff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledga, daath occurred at the time, data and place, and due to the causa(s) and manner as stated.

Medicat Examiner: On the basts of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature end titla of certifiar 29c. Licensa number 29d. Data signad (Month, Dey, Year) 30. Male Road, Westminster, and 2157 32. Registrar's Signatura

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth Dev Month **Physician** 19, 1998 Rufus Harold Gaul January 6:30 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Name (If not institution, giva straat and number) Examiner Cecil 692 Wheatley Road North East If Undar 24 Hrs. 8. Deta of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Yaar 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Deys 15 M 2□ F Months Director 83 January 27, 1914 Pennsylvania 195-05-0536 Usuel Residence of Deceden the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. tnside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner man be notified at 1 ☐ Yes 2 ☑ No Director Earleville Mary land Ceci1 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 190 Tochwogh Drive 21919 United States Funeral e filed within 72 hours after death al Hygiene. other than "natural", or Items 23 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 1 □ Never Merried 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Carpenter Yacht Basin 12 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middla, Last) 12 should be fill h and Mental H ' Is marked oth Be Rufus Andrew Gaul Minerva Gantz 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important if item 27 is any injury or other trai 692 Wheatley Road, North East, MD 21901 Robin Gaul / Son 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cametery, cremetory or other placa) 20c. Location - City or Town, State Jan. 20 1 ☐ Burial 2 ☑ Crametion 3 ☐ Ramoval from State West Chester Pennsylvania 4 ☐ Donetion 5 ☐ Other (Specify) R.A. Ferris Crematory 1998 22. Name and Addrass of Facility
Crouch Funeral Home red con 127 South Main Street, North East, MD 21901 23a. Pert1. Enter the diseesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each tine. Approximata Intervel Between Onset end Death **Physician** tmmediate Ceuse (Finel diseese or condition resulting in deeth) /Medical Adenocarcinona of lunp 18 months Examiner Due to (or as a consequence of) Examiner the ettending physician and hed for use as the burial-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated evants resulting in deeth) Lest Due to (or es e consequença of): the death certificate be execu Box 68760, Physician/Medical Dua to (or as a consequence of) Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Par Kinson's Disease Division of Vital Records, p 24b. Were eutopsy findings eveilebte prior to 24e. Wes en eutopsy performed? Completed hypertention completion of cause of death? ate hes t NIA 1 Yes 2 No 2 No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yas 2 No Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 After this 27. Manner of Death 28e. Deta of tnjury (Month, Dey Year) N (A 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: NIA al or Attanding P s efter deeth. Il Director: After i od in by the funer. 1 2 Neturel 5 Pending Investigation NIA 1 Yas 2 No NIA 2 Accident 28f. Location (Streat end Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Sulcida 28e. Pleca of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours of To the Funeral Di 1 Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the tima, date end pleca, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the best of examination and/or invastigetion, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier edicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of cartifier January 20, 1998 050195 12 30. Neme end eddress of person who completed cause of dath (ttem 23e) (Type, Print)

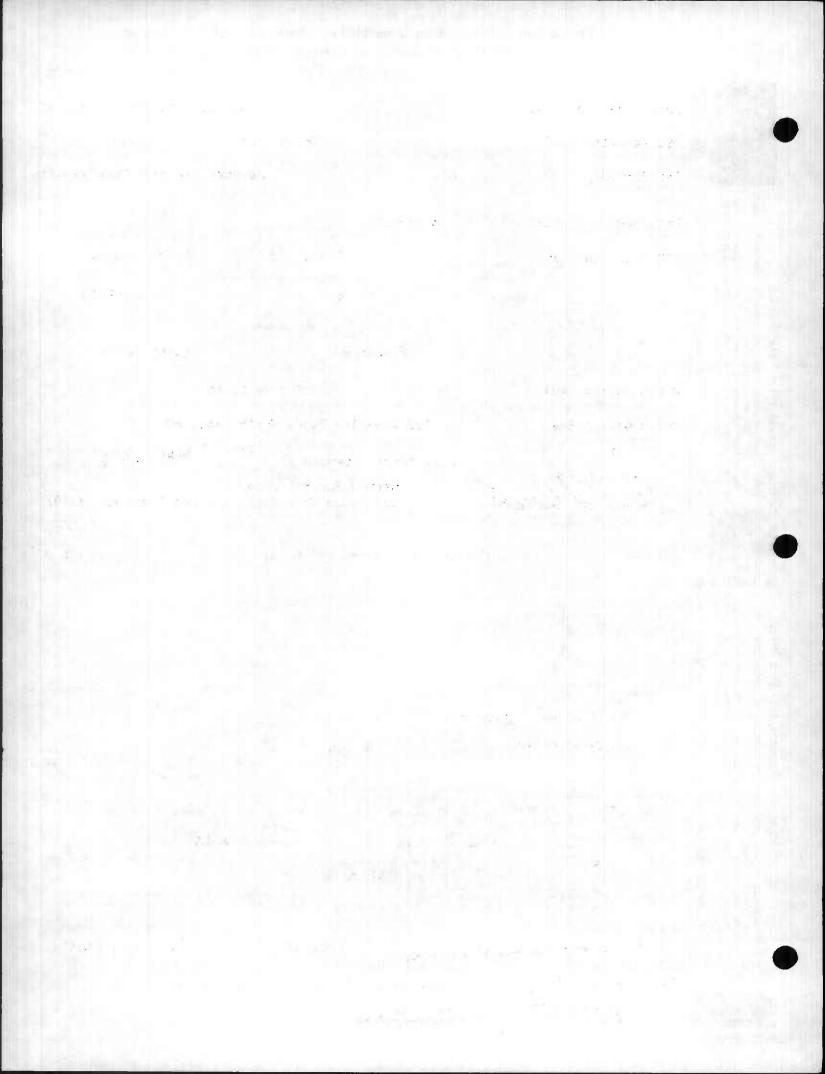
101 Colonial Way : Rising Sun, MD 21911

Julia Davidson-Randell

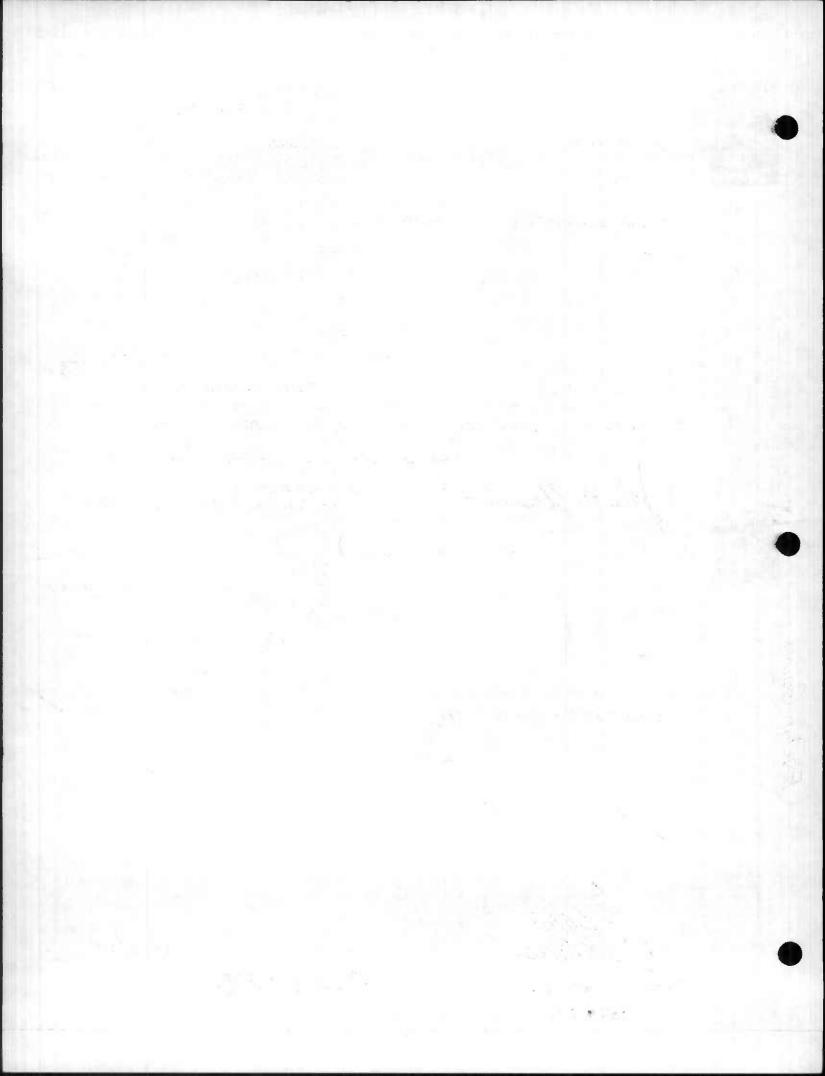
State Registrar Sharon Marie Paylor 101 Colonia
Sharon Marie Paylor 101 Colonia
32. Registrer's Signeture

JAN 2 0 1998

31. Dete filed (Month, Day, Year)



						Cer	tificate	of De	ath	F	Reg. No.	066	94
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A m			b. County		10c. City	, Town or Loc	cation					10d. fns	da City Lim
HE THE	to	Tennessee I	awrenc	e	La	wrence	cebury					1 🗆	Yes 2K
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disal	Completed	15. (Specify o	Decedent's Ed	fucation ida complatad)		16e. Deced	ent's Usuel kind of work	Occupetion done during	most of wor	king	16b. Kind of Bu	siness/Industry	
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end Mentel Hygiene. s marked other than sumatic event, the M		17. Father's Name (Firs.	t Middle I ast)		House	wire	18	Mother's Nen	ne (First, Middle,			
and of	Be	Robert L. (ampbell		•	
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should be deteched for use			wy	W///BOC						24e. Wes	en eutopsy med?	availabla completio	prior to
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State Registrar 31. Dete filed (Month, Day, Year)

32. Registraris Signature

and the same of the

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month Sa N Stepho BrIDITTE 700 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 8. Dete of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 25 F 219-96-5711 Yrs. Director NORTH CAROLINA 04-20-66 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic svent, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No PRINCE GEORGES HYATTSVILLE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 20782 6705 22ND AVE Items 23a Funeral UNITED STATES filed within 72 hours efter death Hygiene. 11. Meritei Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify. à Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Department of Heelih and Mentel Hygiene. Important: If fem 27 is marked other than eny injury or other traumetic awant the second of the se Elementery/Secondary (0-12) College (1-4or 5+) TELECOMMUNICATION SPECIALIST 12th Grade PRIVATE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be DOROTHY VANCE ALVIN C. GREENE 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY GREENE/MOTHER 6705 22ND AVE, HYATTSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND NATIONAL CEM. 01/13 LAUREL, MD 21. Signature Funeral Service Licensee 22. Name end Address of Facility DUDLEY FUNERAL HOME 3200 R.I. AVE. MT. RAINIER, MD 231 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) echnonia Examiner Due to (or as a consequence of): Examiner physician and the buriel-trensit Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that Initioted events resulting In death) Lest Due to (or es e consequence of) Box 68760 Physician/Medical Due to (or es a consequence of): 0 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Were eutopsy findings evailable prior to completion of ceuse of death? Completed peen 20 No 1 □ Yes 2 200 this certificate Hospital or Attending Physicien: 24 hours efter death. Funerel Director: After this certifice Be 25. Wes cese referred to medical examiner? 26. Piece of Death (Check only one) 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specity) 20 1 Inpatient 2 RER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation Netural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide 124 hours e 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner es steted.

2 Adelical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the F 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1998 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) 8158 WISGONSIN 31. Date filed (Month, Day, Year) 32. Registros Si State JAN 12 1998 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Month Vaai **Physician** MARY GIANNAKIS J. 12, 1998 January 11:05 am /Medical 4a. Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Daath 4c. County of Death Examiner Magnolia Gardens Nursing Center Lanham Prince George's If Under 24 Hrs. Hours Min. 5. Sociel Security Number If Under 1 6 Say 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) Funeral 1□M 2\ F Days Yrs. 224-14-0528 Director 78 May 28, 1919 Virginia Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinet numbe notified at 1X Yes 2 □ No Funeral Director Maryland Prince George's College Park 10e. Straat and Number 10f. Zip Code 10g. Citizen of Whet Country? 4802 Nantucket Road 20740 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Detas: 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Ricen, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grede completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pagas 1 and 2 should be filed within 7; Department of Health and Mental Hyglene. important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. Own Home Elementery/Secondary (0-12) College (1-4or 5+) Housewife/Town Treasurer Local Government 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be James Demetrius Szourou Epesteme Unknown 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Paulette Horan - daughter 5115 Crittenden Street, Edmonston, Maryland 20781 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stata M∑Burial 2 ☐ Cremetion 3 ☐ Ramovel from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 1/16/98 Brentwood, Maryland 21. Signifure of Funeral Service Ligense 22. Name end Address of Fecility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part 1. Entar the disease, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one ceuse on each line. Approximata Intervel Between Onsat end Death **Physician** /Medical Immediete Ceuse (Final 1-2 Days Due to (or es e consequence of):

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Paileure disease or condition resulting in death) Examiner Examiner 2-3 WKS The law requires that the death certificate be axecuted buriai-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting In deeth) Lest and Dua to (or es e consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the Dua to (or es e consequance of) datached Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contribute to the cause of death? ate has been signed by the page 2 should be datached 1 ☐ Yes 2 Delo HTIN 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed CHF 24e. Wes an eutopsy parformed? 2 No DM. this certificate 1 ☐ Yas 2 ☐ No al or Attending Physician: The saftar death.

I Director: After this certificate of in by the funeral director, pa 25. Wes cese refarred to medical Be 26. Place of Deeth (Check only one) 1 ☐ Yes 2 No Hospital: Other:

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manyler of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Avetural
2 Accident 5 Pending investigation 1 TYes 2 □ No 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a. To the Funeral D Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end piace, end due to the ceuse(s) end menner steted. Medical 29e. Certifier 29b. Signature end title of/certifiar 29c. License number 29d. Date signed (Month, Dey, Year) 042580 o completed cause of deeth (Item 23e) (Type, Print)
AUJLA. MD 5632 Annapolis Rd. #13. Bladens Gura MD 20710. 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32. Ragistrar's Signature

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth **Physician** 12, 1998 JANUARY 5:44 PM MIRLA COROMOTO GUTIERREZ /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner BETHESDA N.I.H. CLINICAL CENTER MONTGOMERY Hours Min. 8. Date of Birth (Month, Dey, Year) If Under 1 Yeer
Months Deys 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 6. Sex 9. Birthplece (Stete or Foreign **Funeral** 1 □ M 2 🕱 F Country) VENEZUELA Yrs 31 Director NONE Usuel Residence of Decedent with the Marylend 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 TYes 2 □ No Director MD. MONTGOMERY BETHESDA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? pemit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heelth and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must once. 3 POOKS HILL RD. #416 **VENEZUELA** Funeral 11. Merital Stetus 12. Wes Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 Specify: VENEZUELAN 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorcad HISPANIC Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TEACHER PUBLIC SCHOOLS 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be P LUIS ANGEL GUTTERREZ PETRA MARGARITA CASTANEDA 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LUDIM D. GUTIERREZ/HUSBAND SAME AS TTEM 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete TURMERO-MARACAY, 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 1/21/98 4 ☐ Donetion 5 ☐ Other (Specify) METROPOLITANO CEMETERY VENEZUELA 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility MANUSCO MOOO91 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart fellure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician Immediete Ceuse (Finel diseese or condition resulting in deeth) /Medical e. Respiratory Failure
Due to (or es e consequence of): WEEKS Examiner Le Myeloeytic leukemia SIP BOTT Due to (or es e consequence of): Examiner MONTHS ettending physician and for use as the burial-trensit law requires that the death certificate be axecuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Chronic Box 68760. Graft Us Host Dicease MONTHS Physician/Medical Due to (or es e consequenca of): signed by the e P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, þ 2 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed Deen has 1 🔀 Yes 2 | No 1 No 2 No Attending Physician: director, 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 IXInpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No After this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1 Neturel 2 Accident 5 Pending investigation efter death. Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 - Homicide 5 Hospital C 24 hours e Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred at the time, date end pleca, and due to the cause(s) end menner stated. 29e. Certifier Medicai completely (Check only one) To the I within 2. 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Oday. B. Nanavati 1.13.98 MD D 50019 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Uday NanAvaty NATIONAL INSTITUTES OF HEALTH, BETHESDA, MD 20892 31. Dete filed (Month, Dey, Year) -32. Registrer's Signeture

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State Registrar

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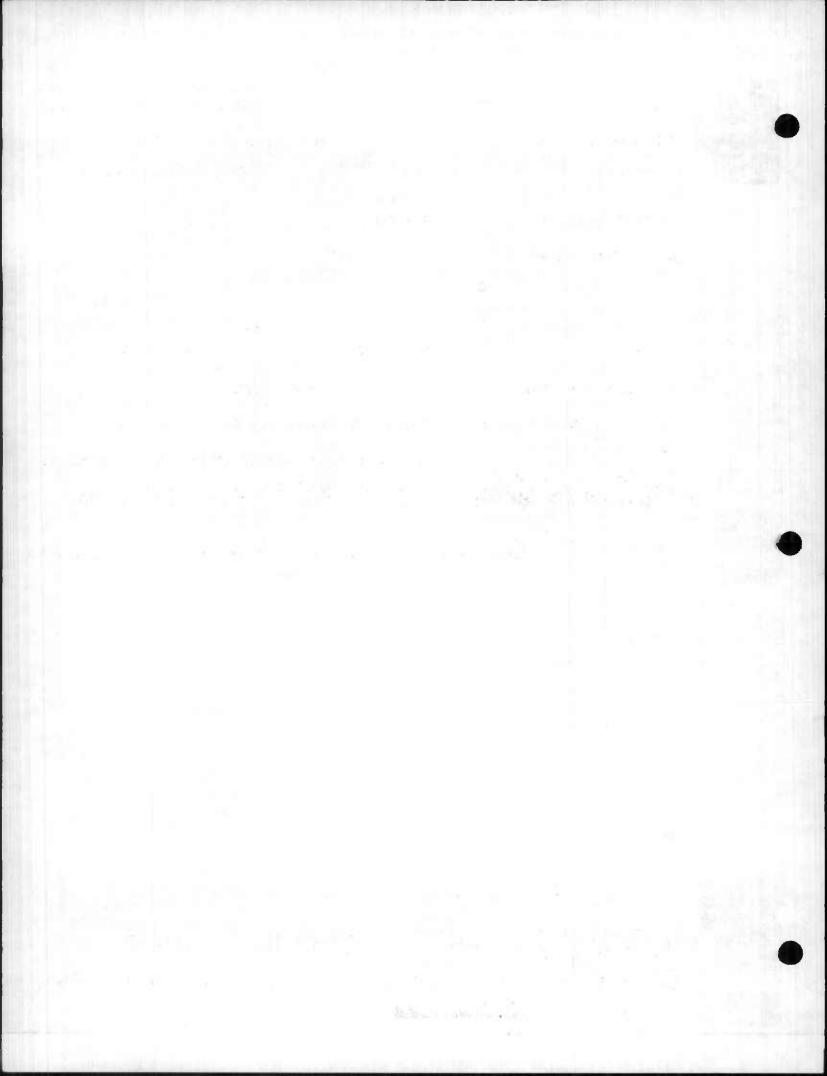
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** JAN. Dey 1998 RUTH COLEMAN **GERARDI** 13 11:39PM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 102 TILGHMAN STREET FEDERALSBURG CAROLINE If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthplace (Stete or Foreign **Funeral** 1□ M 2X F MARYLAND Director 214-28-7873 64 Yrs Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mantel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Maryland of the traumatic event. 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No Director MARYLAND CAROLINE FEDERALSBURG 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 21632 102 TILGHMAN STREET USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 11. Maritei Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Etementery/Secondery (0-12) College (1-4or 5+) OWNER/OPERATOR RETAIL ANTIQUES 9 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be FREELAND MONROE ROBINSON HAZEL MILLS 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) TAMMIE C. PRESLEY/DAUGHTER 5273 PRESTON ROAD, FEDERALSBURG, MD 21632 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burlal 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 ☐ Other (Specify) DORCHESTER MEMORIAL PARK 1/17/98 CAMBRIDGE, MARYLAND 22. Name end Address of Fecility
ZELLER FUNERAL HOME, P. O. BOX 207, 21. Signature of Funeral Service La 106 MAIN STREET, EAST NEW MARKET, MD complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Final 6 months diseese or condition resulting in death) Examiner Due to (or es e consequenca of): Examiner physicien and s the bunal-transit The law requires that the daath certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760, Physician/Medical Due to (or es e consequence of): P.0. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. the 23b. Did tobacco use contribute to the cause of death? à 1 Yes 2□ No 3 □ Probably 4 □ Unknown been signed be should be data Records, by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en autopsy performed? Completed 2 No cartificete 1 Yes 2 No Division of Vital Hospital or Attending Physician: 24 hours efter daath. Funeral Director: Attar this cartifice etaly filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpetient 2 ER/Outpatient 3 DOA 28a. Dete of injury (Month, Day Year) 28b. Time of 27. Manner of Deeth 28d. Describe how injury occurred 28c. Injury et Work? 1. Naturel 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Janes Oliver 503 31. Date filed (Month, Dey, Year) 32 Registrar's Signature State JAN 21 Registrar



		. Decedant's Nama (First, Middle	, Last)		p = 16				2. Data of Dea			3. Tima of Death
sician ledical	ı	Lenole Wiser F	ianson						January	18, 19	998°	10:42 P.
aminer	4	a. Facility Nama (If not institution	, give street and nur	n <i>ber)</i>				4b. City, Town, or	Location of Death	4c. County		
	l	Garrett County	Memorial	l Hospi	tal			Oakla	and	Ga	arrett	
eral tor		Social Sacurity Number 192–10–2688 Isual Residence of Decedant	6. Sex 1 □ M 2 F	7. Aga (In yrs	: last birthday) Yrs.	Month:	er 1 Year Days			1904	9. Birthplec Country New Yo	a (Stata or Foreign ork
	-	0a. Stata 10b. County		10c. C	ity, Town or Lo	ocation			·		10d.	Inside City Limits
ţ		Florida Pine	llas		Largo							Yas 2□No
Director	1	0e. Street end Numbar				10f. Z	ip Coda			l0g. Citizen of	What Country	7
le le		3600 Oak Manor	Lane					34644		U	SA	
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Completed		15. Dacedant (Specify only highas Elementery/Secondary (0-12)	s Education t grada completad)	Acr E ()	16a. Dece (Giva lifa.	dent's Us kind of w DO NOT	ual Occu rork dona usa retire	pation during most of wo	orking	16b. Kind of B	usinass/Indus	try
E O		12	Collega (1	-40r 5+)		Ho	mema	ker			Own Ho	ome
Be		7. Fathar's Nama (First, Middle, I	ast)				mema	18. Mothar's Na	ma (First, Middle,	Maidan Suman		Jille
0		Lee Adam Wise	<u> </u>						Flora Lee	Reigl	e	
	1	9a. informant's Name/Reletionsh	lp (Type, Print)		19b. Meili	ng Addre	ss (Stree	t and Number or F	lural Route Numbe	r, City or Town	Stata, Zip Co	ode)
Ē		Gordon L. Han	son/Son	004	158 Place of Dispo			n Place,	McMurray			0
5	1	1 Burial 2 Crametlon 4 Donation 5 Other (Sc	3 Ramoval from		cemetery, crar	matory or	othar pla	ice)	Data	20c. Location	City or Town	, Stata
	1			Col				, Jan 24	, 1998	Davids	ville,	PA
ODCO.		3. Signature of Funeral Service L	X	an	N.	Jewma	n Fu	neral Ho	mes, P.A.	, 179	Miller 21536	Street
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leted by Physician/M	P	art II. Other significsnt condition	s contributing to de	ath but not rai	sulting in tha u	ndarlyIng	ca <i>u</i> sa gi	van in Part I.	23b. Did to	obacco use co	ntribute to th	e cause of death?
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To Be Completed									1 🗆 Y	as 2 No	1 🗆 Y	
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	2	7. Manner of Deeth	28a. Bata c	f injury	28b. Tima of Injury	f	28c. Inju Wo	ry at rk?	28d. Describa h	ow injury occur	red	
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ertificat	3 ☐ Suicida 6 ☐ Could not be detarmined 28a. Place of Injury - At home, farm, streat, factory, office building, afc. (Specify)								28f. Location (Straat end Number or Rural Routa Number, City or Town, Stata)			
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State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Jamonth. Dey 1998 eer Madelyn 3 Renee 6:50AM Hart /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 502 Fourth Street Caroline Denton | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | NOV • 25, 1997 9. Birthplece (State or Foreign Country)
Del. 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1□M 2√2 F Yrs. Director 215-51-3284 Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Md. Caroline Denton Yas 2□No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 502 Fourth Street 21629 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Yeer or Detas: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examinations. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: Caucasion by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) N/A N/A 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kevin Renee Payne 19e, Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Hart/Father 502 Fourth St., Denton, Maryland 21629 20b. Plece of Disposition (Name of cemetary, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Denton Cemetery 1/5/98 Denton, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Nama and Address of Fecility Moore Funeral Home, P.A., 12 S. 2ndSt. HOWE Denton, Maryland21629 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heert feilure. List only one ceuse on aach line. Approximate Onsat and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in deeth) Obstructive apnea l month, 10d Examine Due to (or es a consequence of): Examiner Micrognathia 1 month, 10d attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, laading to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initiated evants resulting in deeth) Lest Due to (or es a consequence of): Trisomy 13 Box 68760. 1 month, 10 Physician/Medicai Due to (or es e consequance of): days P.O. F signed by the aid be detached for Pert II. Other eignificent conditions contributing to deeth but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, by been sig 24b. Were eutopsy findings aveilabla prior to completion of ceusa of deeth? Completed 24e. Wes an autopsy performed? page 2 s 1 Yas 2 No 1 ☐ Yes 2 No certificate Division of Vital Hospital or Attending Physician: 24 hours effar death. Funeral Director: Affar this certifica etaly filled in by the funeral director, g 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? 1 Natural 2 Accident 5 Pending invastigation 1 ☐ Yes 2 ☐ No congenital Congenital 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours or To the Funeral C completaly filled 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

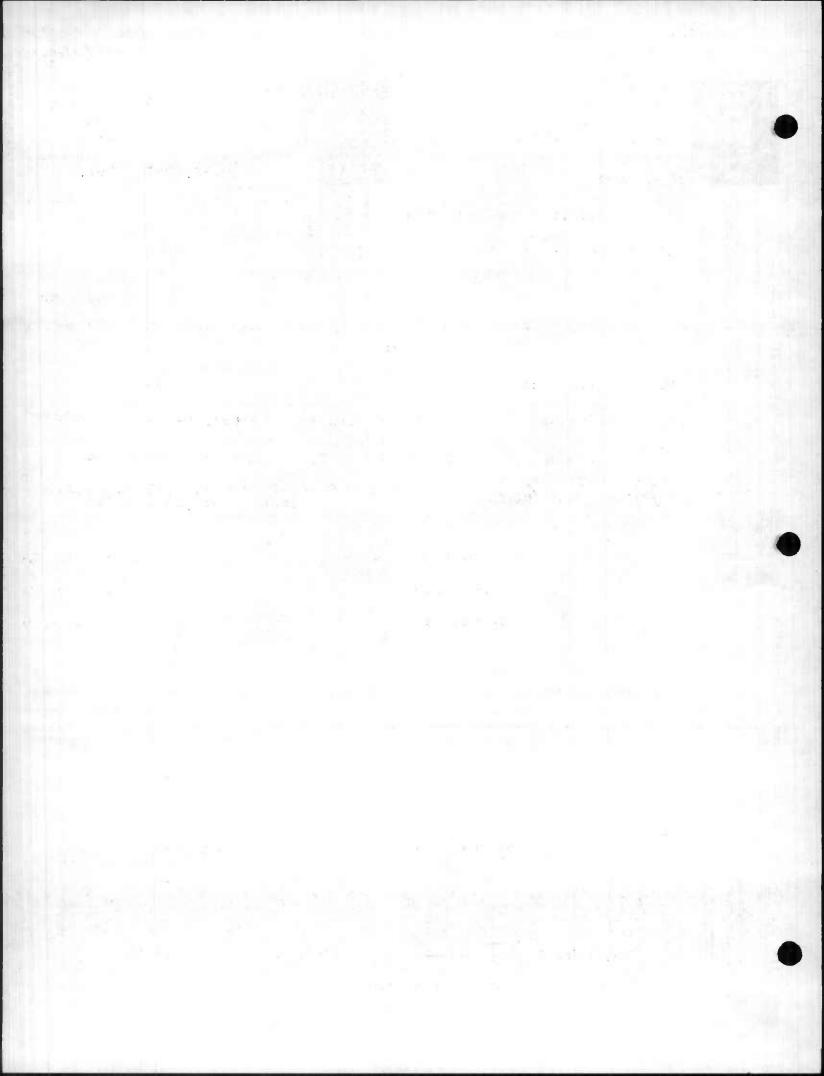
| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end menner stated. Medical 29b. Signature and litle of certifier 29c. License number 29d. Dete signed (Month, Day, Year) C1002720 1/7/98 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Harry A Lehman, III, MD, 411 N. Shipley St., Seaford, DE 19973

wha Davidson-Randall

32. Registrar's Signeture

State Registrar 31. Data filed (Month, Day Year) 98



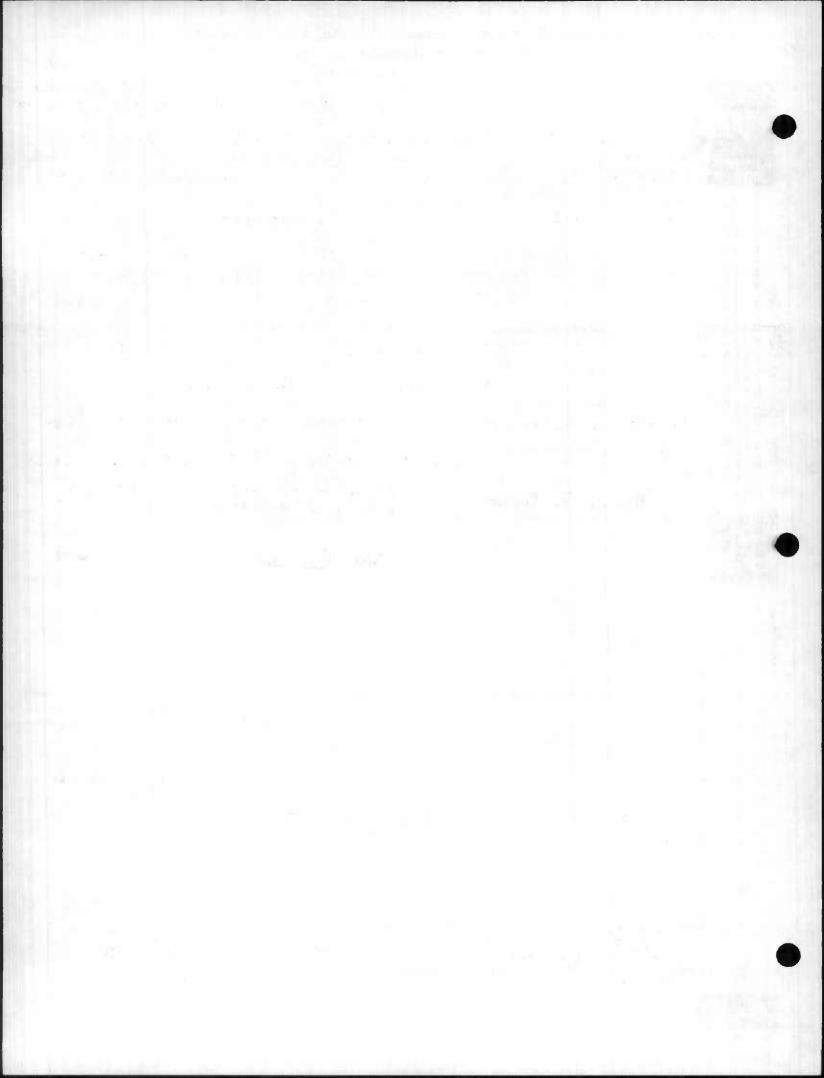
State of Maryland / Department of Health and Mental Hygiene []

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Dey 1 0 1 9 9 8 JANUARY HUNT 3:35 PM FRANCES FANNIE /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SHORE NURSING & REHABILITATION CTR. DENTON CAROLINE If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** Deys 1 M 200 Yrs Director 72 222-16-0576 03/03/25 Delaware Usual Residence of Decedent the Menyland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show tem 27 is marked other than "neturel", or items 23s or 28s-f sho other treumstic event, the Modical Experience must be notified at Director Caroline Federalsburg 1x Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 220 01d Denton Road 21632 death Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 "neturel", or 1 ☐ Yes 2 ☑ No g Specify: **Black** 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "n any Injury or other treumetic event Elementery/Secondary (0-12) College (1-4or 5+) Poultry Processor 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Isaac Johnson Mary Anderson 2 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 505 Riverview Gardens, Denton, MD 21629 Dorothy Q. Hunt/Niece 20b. Pleca of Disposition (Neme of cemetery, crematory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Pleasant Cem. 1/17 Preston, Maryland 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility Framptom-Hawkins-Eskow Funeral Home Eskero PO Box 43, Federalsburg, MD 21632 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physiclan** /Medical Immediate Ceuse (Finel ancer disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner attending physician and for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequença of). Box 68760. certificate be Physician/Medical Due to (or es e consequenca of): asi signed by the a P.O. Pert II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24e. Wes en autopsy performed? 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? Completed peen hes page 2 1 ☐ Yes 2 No certificate Division of Vital of attending Physicien: effer death.

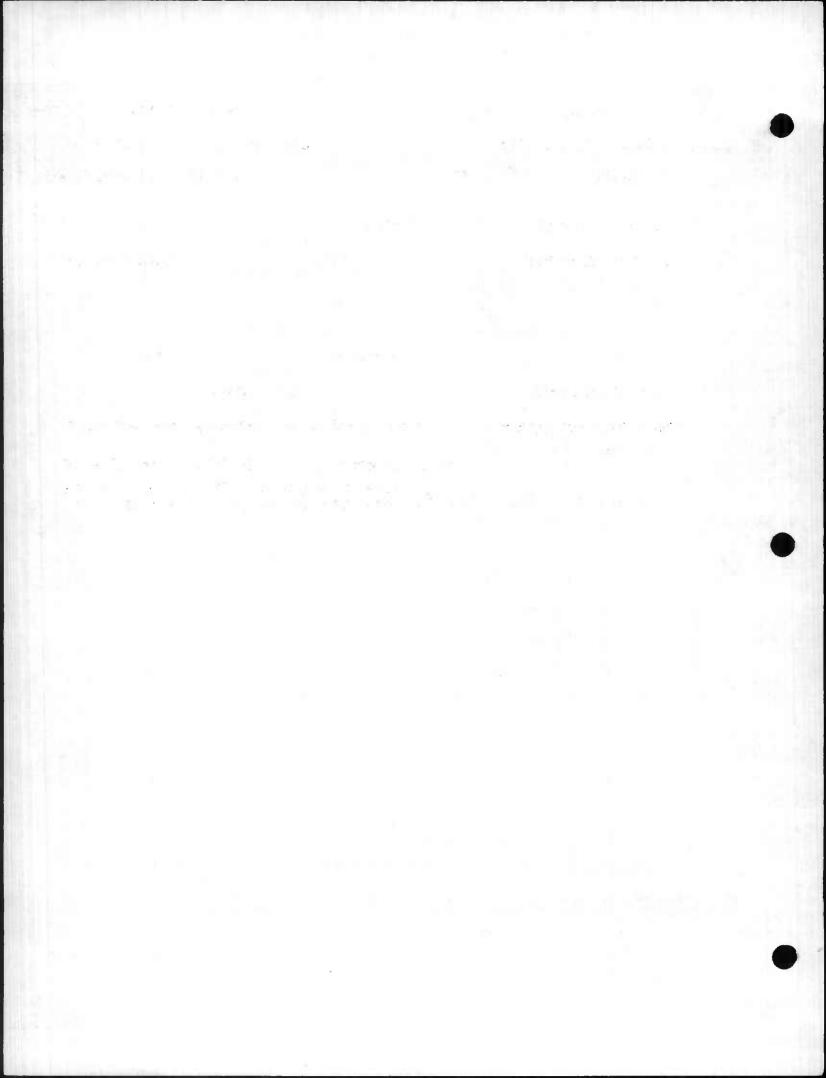
Director: After this certifications Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1º 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. fnjury et Work? Naturai 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral D 29a. Certifie Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and mention es stereu.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. Medical pletely (Check only one) 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signature and the of contrio 117(20 D32036 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print) GARY SPROUSE 2108 DIDONATO DRIVE CHESTER, 21619 31. Dete filed Month, Day, York 32 Registra's Signature Randell State

Registrar



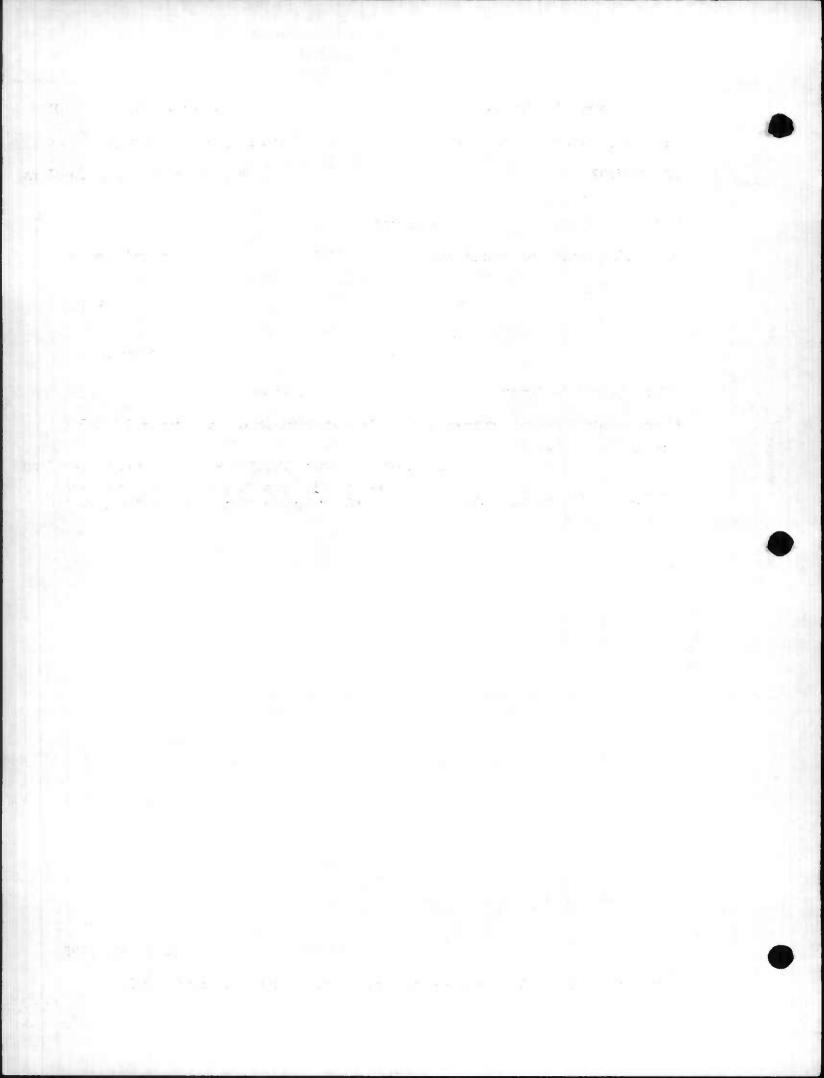
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Important: if item 27 is marked other than "natural", or items 23s or 28s-f show eny injury or other traumatic event, the Medical Examiner mast be notified at 200.9. To Be Commissed by Euroral Disasters	Director	Maryland Howa	rd		Colum	bia						1 🗆 Yes		
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D32778 January 15, 1990 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)			I dem ?	Shirt	MK			2778						

32 Aggistrar's Signeture Julya d'audion Rardall

State Registrar 31. Dete filed (Month, Day, Year) JAN 16 1998



State of Maryland / Department of Health and Mental Hygiene G-757_3/10/98^r €ertificate of Death Items: 5, 11 per F.H.

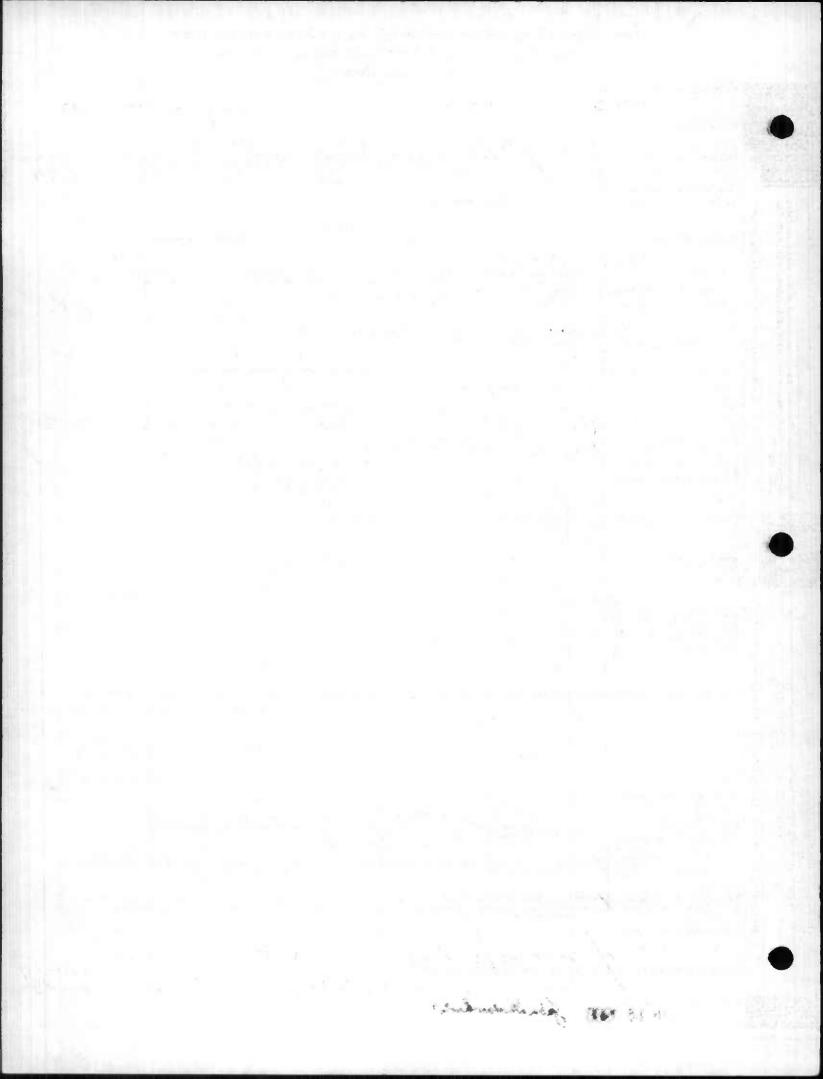
1. Decedant's Name (First, Middla, Last) 2. Data of Daath 3. Tima of Daath Month **Physician** DERRICK HOLSTON 11, 1998 4:40 PM January /Medical 4e. Facility Neme (If not institution, giva streat end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timorE Hopkins ohn 0 If Undar 1 Yaar If Under 24 Hrs. 5. Social Sacurity Number 8. Data of Birth 6 Sax 7. Age (In yrs. last birthday) **Funeral** 100M 20 F Months Deys Hours Yrs Director Usual Rasidance of Decedant 10s State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryla Vas 2□No Director PALTIMORE 7 is marked other than "natural", or items 23a or 23a-1 traumatic event, the Medical Examiner must be notified 10s. Street and Number 10f. Zlp Coda 10g. Citizan of Whet Country? 380 BASH Funeral 11. Marital Status Was Decedent Evar In U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yes or No if Yes, specify Cuben, Maxican, Puarto Rican, atc.) Race - Amarican indien, Bleck, Whita, atc. permit. Pages 1 and 2 ahould be filed within 72 hours after c. Department of Health and Merhal Hygiens. Important: if item 27 is marked other than "natural; or item any injury or other traumatic event, the Medical Examination. 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Datas: t Never Married 2 Married 1□ Yas 2万No Baltimore, Maryland 21215-0020 Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elementary/Secondary (0-12) Coilaga (1-4or 5+) ONTRACTOR 10 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) 86 2 VII ORD 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Willisten SC 1068 70% 20b. Placa of Disposition (Nama of cemetary, crematory or other place 20a. Mathed of Disposition 20c. Location - City or Town, Steta 1 Burial 2 □ Cremation 3 □ Ramoval from State ORDAN \$ ☐ Other (Specify) 21. Signature of Funeral Service Licent 22. Neme and Address of Fecili ral GREEN 408 N BLACK VIII, BIAH 29817 complications that caused the deeth. Do not antar tha moda of dying, such as cardiac or respiretory errast, only ona cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximata Interval Batween Onsat end Deeth **Physician** /Medical Immediate Causa (Final diseasa or condition rasulting in deeth) Examiner Dua to (or as a consequance of): Examiner physician end s the buriel-trensit Sequentially list conditions, if eny, leading to immadiete cause. Enter Undarlying Cause (Disaese or injury that initieted evants rasulting in daeth) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): signed by the e Pert II. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Y98 2 ☑ No 3 □ Probably 4 □ Unknown à 24b. Wara eutopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? peen certificate hes 1 🗆 Yas 2 No i or Attending Physician: effer deeth. Director: After this certifice 25. Was case rafarred to medical Be 26. Placa of Death (Check only ona) examinar'i Othar: 4 Nursing Homa 1 Yes 2 No 5 Rasidance 8 Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Deta of Injury (Month, Dey Year) funeral Certification: 27. Mannar of Death 28c. tnjury et Work? 28d. Dascribe how Injury occurred 28b. Tima of 1: Natural 2 Accident 5 Panding 1 ☐ Yas 2 ☐ No invastigation the 6 Could not be datarminad 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) Place of Injury - At homa, farm, straat, factory, office building, etc. (Spacify) pletely filled in by 4 - Homicide Hospital of 24 hours e 29a. Cartifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end mannar stated. Medical To the To the Complet 29b. Signature and title of gertifier 29c. Licansa number 29d. Date signed (Month, Dey, Yeer) 30. Name a daath (itam 23a) (Type, Print) JHOC GON Caroline St 7

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Registrar **DHMH 16 Rev 6/95**

State

31/ Date fil



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 2 3 0 7

					(Certificate	of Death		Reg. No.			
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Funeral		5. Social Security Number 6. Sa	nx · 7. Age	(In yrs. le		Months D	aar If Undar 24 Hr eys Hours Mir		th ly, Year)	9. Birthr	olece (Stete or Forai	ign
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p ku		10a. State 10b. County		10c. City,	Town	or Location					10d. Inside City Limit	its
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20 after death with the Marylar or thems 23a or 28a-f show insiner must be notified at	Funeral	11. Marital Status	12. Was Decedent E	var in U,S	3.		of Hispenic Origin? (Cuban, Mexican, Pue	Spacify Yas or No		ca - Americ		
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uted d ansit	Examiner	Sequentially list conditions	b	ue to (or	es e co	onsequenca of):						-
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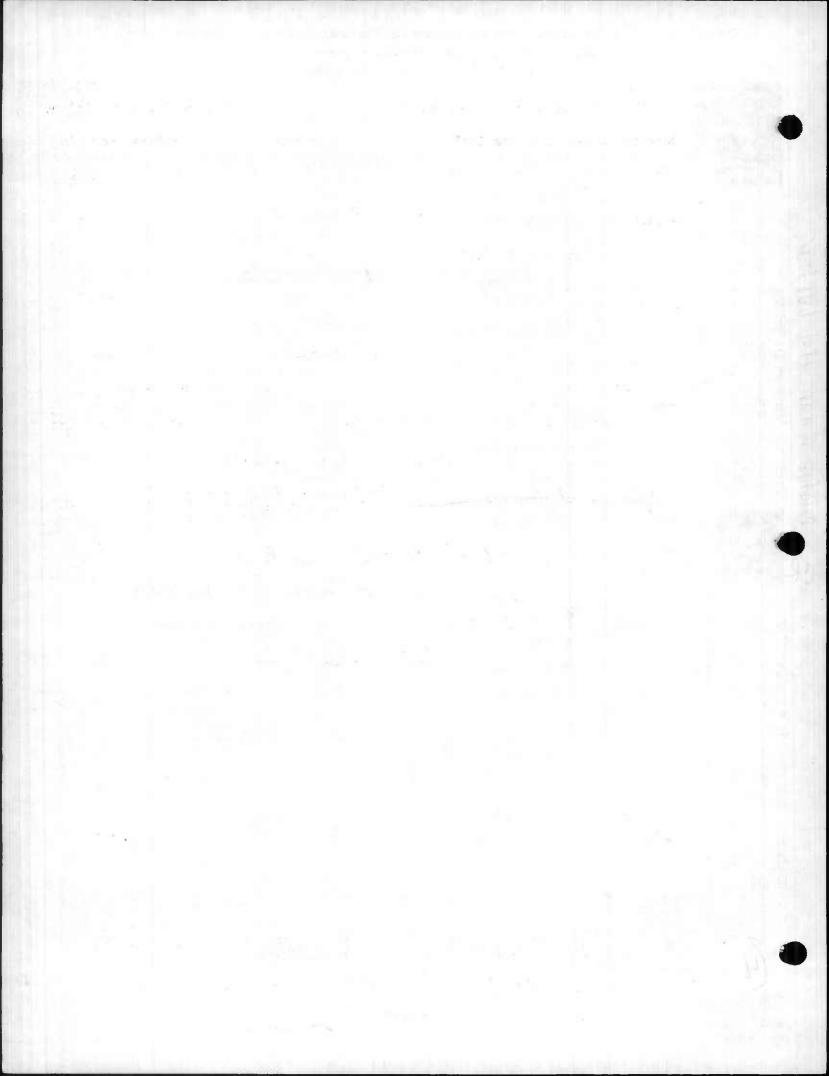
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1. Decedent's Name (First, Middle, Las	t)			tificate of		2. Data of Dea		V	3. Time of Death
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	and		Usuei Residence of Decedent 10a. Stata 10b. County		10c. Ci	ty, Town or Lo	cation				11	0d. Insida City Limits
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adys	pemit. Pag Depertment Important: I any Injury o		21. Signeture of Funerel Service Licens (Charles J	Lowns			Neme end Addre	ess of Fecility Jenkins	Funera			
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-	Sing P	tlon:	27. Manner of Death 1 Accident invastigation	28e. Date of In (Month, D	jury Jay Year)	28b. Time of Injury	28c. Injui Wo	ryet rk? Yes 2 □ No	28d. Describe h	ow Injury occur	red	
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	Hospita 24 hours Funeral (tely fille	edicai C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the bes ner: On the basis end manner s	of examina	owledge, death ation end/or inv	occurred et the tire estigetion, in my o	me, date end placa, ppinlon, deeth occur	end due to the o	euse(s) end me late end place,	enner es st end due to	eted. the ceuse(s)
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	(4)		30. Name end eddress of person who c	ompleted sauss of	death /lton	n 23a) /Tune f	Print)	1040		(-(u
	(1)		OR MUSHTAO 31. Data filed (Month, Dey, Yeer)	SHAW	trar's Signe	27-A	VOMIL	ER PARK	WAY,	REPR	TI	MD 2077C
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DHMH 16 Rev 6/95

JAN 14.1998



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Physician HERNDON M. PRISCILLA 1998 1:15 PM January 1 /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Yeer) **Funeral** Deys Hours 1 □ M 2 □ F 92 Yrs. 577-24-4857 **Director** March 13,1905 Maryland Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f ahow traumatic evant, the Medical Exemples must be not lined at 14 Yes 2 □ No Washington Director N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20011 U.S.A. 4511 Arkansas Avenue N W permit. Peges 1 and 2 should be filed within 72 hours after death 1 Department of Haelth end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examinations. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Merrled Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 ☑ No Specify: ð 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) U.S. Government Custodian 6th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Margaret Ford James Hill 19a. Informent's Name/Reletionship (Type, Print)

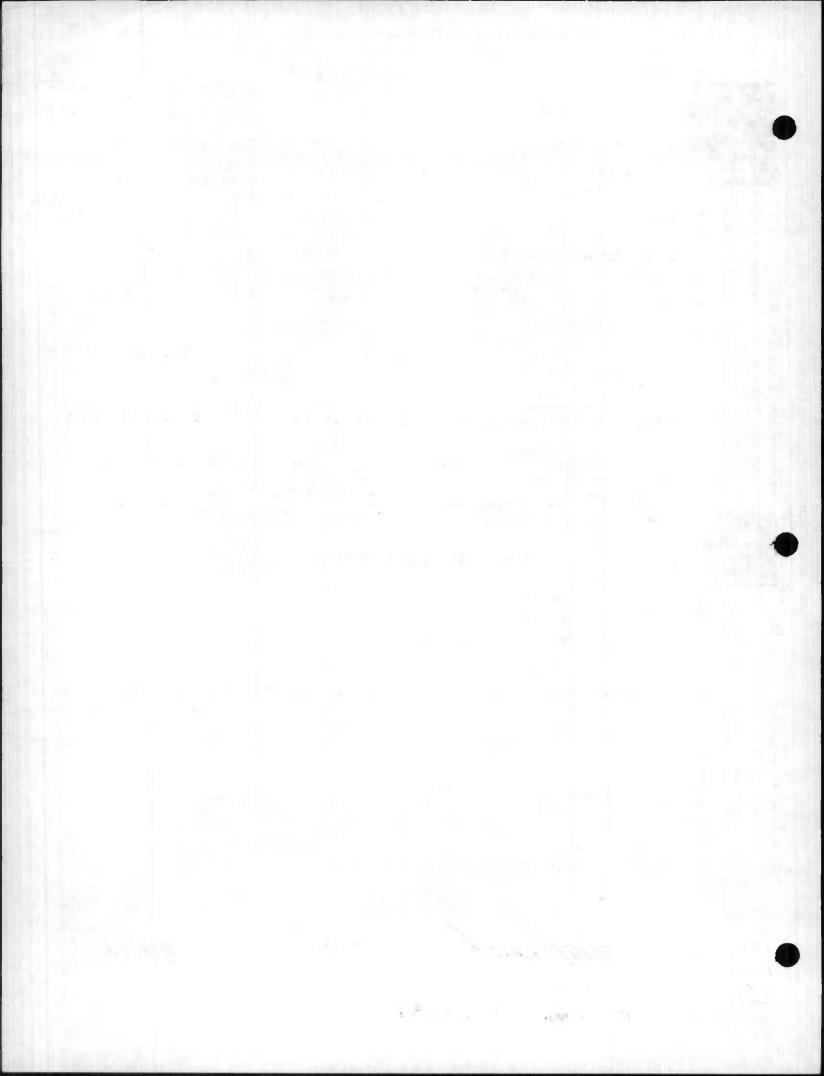
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)

Catherine Herndon-Daughter-in-law 4511 Arkansas Ave., N W Washington DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20e. Method of Disposition 20c. Location - City or Town, Stete I Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) Harmony Memorial Park 1-6-98 Landover, MD 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility Marshall's Funeral Home, Inc. mish 23a. Petr. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approx. Interval. Approximete Interval Betw Onset and Deeth **Physician** Immediate Ceuse (Finel diseese or condition resulting In deeth) /Medical e. Gastrointestinal hemorrhage 4 days Examiner Due to (or es e consequence of). Examiner requires that the death certificate be axecuted the attending physician and hed for use as the burial-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or as e consequença of): Box 68760. Physician/Medical Due to (or as e consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? paga 2 should be detached signed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. à 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? peed certificate hes 1 ☐ Yes 2 ☐ No director. 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes ≱□ No 1 X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) funarai 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: or Attending Fafter death.

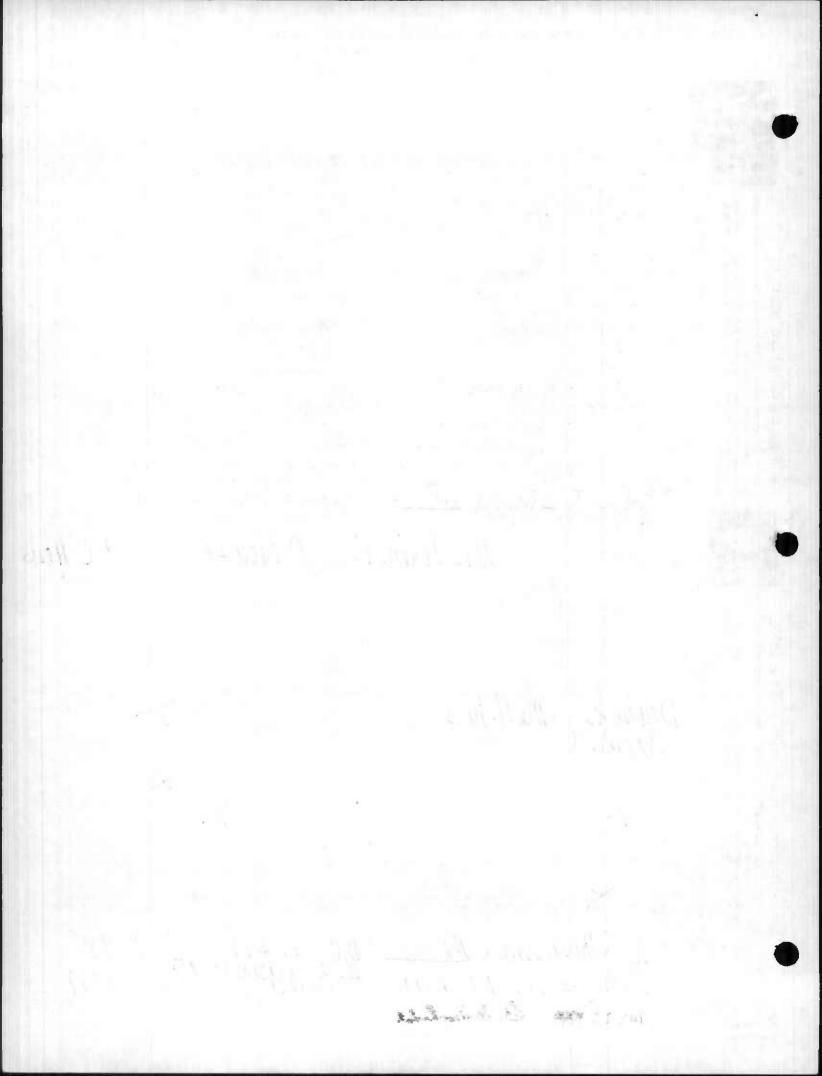
Director: After d in by the funar 5 Pending 1 □ Yes 2 □ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, offica building, efc. (Specify) 4 I Homicide Hospital 24 hours 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical 2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end pleca, end due to the ceuse(s) end menner steted. (Check only To the I within 2 29b. Signeture end title of coglifie 29c. License number 29d. Dete signed (Month, Dey, Yeer) D09834 DRS 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Barry Rosenbaum 3720 Farragut Ave., Kensington, MD 20895 31. Date filed (Month, Dey, Year) 32 Registrar's Signeture State Si Musikar Radali Registrar JAN 15 1998

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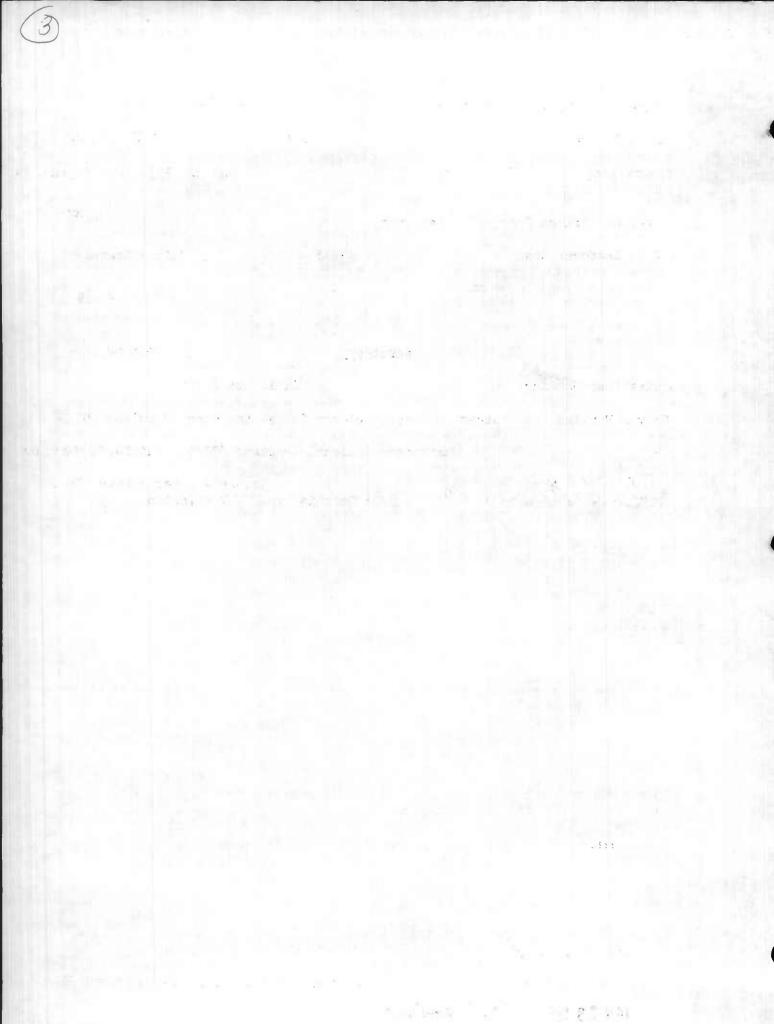


State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate of	Death	F	leg. No.	UZ	2310
			1. Decedent's Name (First, Middle, La	ast)					2. Date of Dee		V	3. Time of Death
	ysicia Medic		Evelyn H	Howell					Januar	v 8 1	Year 998	1:05 PM
	amin		4a. Facility Neme (If not institution, git	ve street end numb	er)			4b. City, Town, or	Location of Death	4c. County		1.05 111
			1884 Iverson S	+				Town 1	- III-11-	D., 3		
Fun	oral			-	Age (In yrs. last b	birthday)	If Under 1 Year	If Under 24 Hr	e Hills s. 8. Dete of Birth	Pri	9. Birtho	eorge s
Dire			579-40-4875	1□M 2፟MF	91	Yrs.	Months Days	Hours Min	8. Dete of Birth (Month, De) Jan. 6	, Year)	Coun	place (State or Foreign try) D.C.
		1	Usual Residence of Decedent		71				Jan. 0	, 1907	wasii	, D.C.
yland W	14		10a. State 10b. County		10c. City, To	wn or Lo	cation				1	0d. Inside City Limits
Mar	Di l	to	District of Colu	ımbia		Wa	shington	1				1∭ Yes 2□No
the 284	De la	2	10e. Street and Number				10f. Zip Code			log. Citizen ot 1	Whet Cour	itry?
¥ e	2	₫	1222 G St., N.	E.				20002				
ire, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours after death with the Maryland sheath and Mental Hygiena. It Health and Mental Hygiena.		Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.S.	13 V	Vac Decedent of		Specify Vee or No.		cea 5	tates
tar deat	H H	5	1 Never Married 2 Married	Armed Force	es?	IS. If	Yes, specify Cut	en, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		ck, White,	
21215-0020 within 72 hours af giena.	8	by	3 € Widowed 4 Divorced	If Yes, Give		1	☐ Yes 2X No	Specify:		Specify	/: B1	ack
Do nod	- H		11			0.00	and the second	- 4				
72	alpe	Completed	15. Decadent's E (Specify only highest gro	ade completed)	16	(Give	ent's Usual Occu kind of work done	pation during most of wo	orking	16b. Kind of B	usiness/inc	Justry
12 vithii	3	밑	Elementery/Secondary (0-12)	College (1-4	or 5+)	me. L						
122	벌		12th				Housewi	T			rivat	e
De f	8 ×	Be	17. Father's Name (First, Middle, Last					18. Mothers Na	me (First, Middle,			
Baltimore, Maryland 21215-002 permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiena. Important: if item 27 is marked other than "naturel".	artic	2	Charles Josep							lumphri		
Aan and and and and and and and and and a	TUE.		19a. Intormant's Name/Relationship (Type, Print)	19	b. Mailin	g Address (Stree	t and Number or F	Rural Route Numbe	r, City or Town,	State, Zip	Code)
1 and Health	T .		Marie Howell Mar	shall/Dau	ughter	1884	4 Iverso	n St., T	emple Hil	1s, MD	207	48-5712
	to		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetlon 3 ☐	70		of Dispos	sition (Name of natory or other pla		Date	20c. Location -	City or To	wn, Stete
Baltimore, permit. Pages 1 an Department of Hear Important: If item	7		4 □ Donation 5 □ Other (Special	JHemovel from Sta fy)		nator	Nation	al Com	1/20/98	Arlin	arton	VA
Trit.	는 e		21. Signature of Funeral Service Licar	nsee	ALIII		Name and Addr					, VA
m ade	eny le		IND T	<+ ·	A 111			3	tewart Fu			010
			1/0/W 1.	Mewan	X 111			-	N.E. Was		3. 20	
			23a. Pert1 Enter the disease, or com shork, or heart tailure. List only	one cause on each	sed the deeth. Do h line.	not ente	r the mode of dy	ing, such es cardia	ac or respiratory an	est,	j	Approximate Interval Between
Physic	_	1	V	1	1/		. !	1			į	Onset end Death
/Medi Exami	_		Immediete Cause (Final disease or condition resulting in death)	. 1	+12 n	gm.	113	1.) 11	eude			6 HOMS
LAGITII	•		resulting in death)		Due to (or as a	a consequ	uenca ot):					92010
70 2	=	<u>e</u>										
ecords, P.O. Box 68760, law requires that the death certificate be assouted as been signed by the attending physician and	rans	Examiner	Sequentially list conditions.	b. ————	Due to (or es e	e consequ	uence of):					
9 9 9 9			Sequentially list conditions, if any, leading to immediate cause. Enter UnderlyIng Cause (Disease or Injury									
68760, ficata be ay physician	, e b	Medical	that miliated events	C	Due to (or es a	consequ	ienca of):				-	
riffica ng ph	as t	8	resulting in death) Last									
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Box laath cer	for .	Physician	Don't Other of Little and any distance			1 4					-	
IS, P.O. es that the da	che	lys	Part II. Other algnificent conditions of	M / geath	nyout not resulting	in the un	denying cause gi	ven in Paπ I.		\		the cause of death?
Or ta b	deta		1)ianells	11/2/1.1	H				1 D Y	08 217 NO	3 Prob	bably 4 Unknown
of Vital Records, Physician: The law requires t	8	by	1	,					269		041 111	
cord v require been sig	nor .	Completed	Dremia						24a. Wes e	n eutopsy med?	976	ere autopsy findings
Rec law	20	ğ								,	of c	mpletion of cause death?
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Vital I	tor.	0	25. Was case referred to medical					26 Place of De	eath (Check only or	(e)		
of Vita Physician: this certific		0 8	examiner?	Hospital:	atient 2 ER/C	Jutnationt	3□ DOA Ot	her: 4 Nursing		enca 6 □Oth	er (Specifi	al .
Q 4 #	76		27. Manner of Death	28a. Dete of In (Month,		Time of	28c. Inju		28d. Describe h			7
On ding in.	ş .	흥	1 Netural 5 Pending Investigation		Day Year)	Injury		rk?]Yes 2⊡No				
Division or Attending after death. Director: After	the state of	Certification:	3 ☐ Suicide 6 ☐ Could not b	e one Place of	Injury - At home, f	farm etro			28f. Location (S	treet end Numb	er or Rura	/ Route Number,
Or A saftar	ë.		4 ☐ Homicide determined	building,	etc. (Specify)	iaiii, Sile	et, tactory, omce		City or Tow	n, Stete)	or or mara.	riodia ridiliber,
often urs sal	B .		20-0-45	-								
Hospital 24 hours Funeral	tely	edical	(Check only 2 Medical Exar	nysician: To the be niner: On the basis	of examination e	ge, death ind/or inv	occurred et the ti estigation, in my	me, dete end plac opinion, death occ	e, end due to the c urred at the time, d	ause(s) and ma ate end place,	nner as stand due to	ated. the cause(s)
the state	eld .	-	one)	and manner	stated.		00.11	`				
Divisio To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A	8		29b. Signature and title of partifier		h.		29c. Licen	se number	70 3	9d. Date signe	3 (Month, L	Jay, Year)
0	1		Sum	men	10)		0) (1	162	.18	1-9	- 9	8
12	5)		30. Name and address of person mo	coup ted cause o	ot death (Item 23e)	(Type, F	Print) 1/2/	Varil	IM. St	18		410
6	/		LATHY S	1SPP 1	Wemn	111	" "	AShill	ation	DC	20	017
	State	е	31. Date filed (Month, Day, Year)	2. Regi	strar's Signature			1	1			
Reg	gistra	-	JAN 15 1998	90000	tudger la	Let						



IS Item	ns:23a part I,27,28	a-f per MEO					Mental Hy	Reg. No.		
sician	Decedant's Nama (First, Mide	dle, Last)					2. Date of De	Day		Time of Death
edical		Denise	Hawkins			. O. T.	JANUARY			15P.M.
miner	4a Facility Name (If not institution 7412 LANDOVER		num <i>ber)</i>			LANDOVE	r Location of Deat		E GEORG	ES
	5. Social Sacurity Number	6. Sax	7. Aga (In yrs.	lest hirthday)	if Undar 1 Yaar	if Under 24 Hr				
tor	219-72-5408	1□M 280 F			Months Days	Hours Mir		2, 1959		(State or Foreign
	Usual Residence of Decedent 10a. State 10b. Count		100 0	ity, Town or Loc	ention				104 1	nsida City Limits
Funeral Director										Øyas 2 No
Director	Maryland Pr:	ince Geor	ge I	andover	10f. Zip Code			10g. Citizan of V		
ō	7412 Landove	D 1								
era	11. Marital Status seper		ecedent Evar in U	J.S. 13. W	2078.		Specify Yes or No	United 14. Rac	a - American In	dian,
by Funeral	1 Never Married 2 Ma 3 Widowed 4 Divorce	rried 1 Ye	s 251No Give		Yas, specify Cub Yes 2 XNo	an, Mexican, Pue Specify:	rto Rican, etc.)	Specify Specify	ck, White, atc. V: Blac!	ζ
9		nt's Education		16a. Deced	ent's Usual Occup	pation		16b. Kind of B	usiness/Industry	
plei	(Specify only high Elementary/Secondary (0-12)	est grede complete	d) ı (1-4or 5+)	(Give I lifa. D	and of work done O NOT use retire	during most of ward)	orking			
Completed	Liementary/Secondary (0°12)	5T	(1-401-54)	Secre	tary			UnKı	nown	
Bec	17. Fathar's Nama (First, Middle	, Last)	L-1711 CH			18. Mother's Na	ame (First, Middle	, Maidan Suman	10)	
TOE	Grover Dean Ha	awkins				Willie	Mae Ema	nue1		
-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailin	Address (Street	end Number or F	Rurel Route Numb	er, City or Town,	State, Zip Cod	9)
	Grover Hawkin	ns F	ather	8626	Reiche	r Street	Landove	r, Maryl	land 20	785
т	20a. Method of Disposition		20b.	Plece of Dispos	ition (Name of atory or other pla	ce)	Data	20c. Location -	City or Town,	State
37	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (m State Was	hington	Nation	al Cemet	ery1/21/	98 Suit	tland, l	Maryland
	21. Signatura Funeral Service	Licerson	110	22.	Nama and Addre	ess of Facility L	atney's	Funeral	Home,	Inc.
	23a. Part1. Enter the disease, of shock, or heart failure. Lis	WHarr	4 693	7 38	31 Georg	gia Ave,	NW Wash	ington,		1 1 roximate
edical Examiner	Immediate Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate	aS		or as a consequence or a consequence or a consequen						
	if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury thet initiated events									
Medical	thet initiated events resulting in death) Last		Due to (or as a consequ	ence of):					
ian										
Physician/Me	Part II. Other significant condit	lons contributing to	death but not res	sulting In the un	derlying cause gi	ven in Part I.		tobacco use co Yss 2□ No	ntribute to the	causs of death?
by P							-			/\
Completed								s an autopsy ormed?	availab	utopsy findings le prior to tion of cause n?
E							1,20	Yes 2□No	1 12 Ye	s 2 No
BeC	25. Was case referred to medic	al				26. Placa of D	aath (Check only			
0	examiner? 1 Tyyes 2 □ No	Hospital:	Inpatiant 2	ER/Outpatient	3□ DOA Ot	her.	Home 5 ₹ Res		ner (Specify)	
n: T	27. Manner of Death	28a. Da	te of Injury	28b. Time of	28c. Inju Wo			how injury occur		
atio	1 ☐ Natural 5 ☐ Pand 2 ☐ Accident inves	tionation in the	1/13/98	injury unknown		Yes 2 KNO	subject s	strangled		
Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Pla	ica of Injury - At h	nome, farm, stre	et, factory, offica		28f. Location	(Street end Num I	ber or Rural Ro	ute Number,
Sert	40 Homicide		at reside					iwn, State) 741 Md. 2078		er Ku.,#F
edicai C		ing Phyaiclan: To t	he best of my kno	owledge, death			ce, and due to the	cause(s) and ma	anner as stated	
Mec	29b. Signatura and title of cartif		Marian States.		29c. Licens	se number		29d. Date signe	ed (Month, Dey,	Year)
	1-100	111.	~		0.0	ME		TANTINING	14 1000	
	20 Name and address of	M. Ke	- Jano	m 22e) /7: 1		C.M.E.		JANUARY	14, 1998)
	30. Nama and address of perso	1.10	use of daath (Ite	m 238) (Type, I		n Ct	+ Dal+4	mores Ma	Pace Land	21201
Clot	31. Date filed (Month, Dey, Yea	/	Registrar's Sign	ature	TIT Per	ni stree	t, Balti	more, Mo	тутана	21201
State	IAN 90	/	A 84 4	PR						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 45 Hibberd, Sr. William Janney PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 801 Green Valley Rd. New Windsor Carrol1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 31, 1918 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 11X M 2□ F 79 Yrs 220-05-3174 Usual Residence of Decedent 10h Count 10c. City, Town or Location 10d. inside City Limits New Windsor 1☐Yes 2⊠No Marvland Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21776 U.S.A. 801 Green VAlley Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2₺ No Specify: Specify: 3 ☑ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) farmer dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Granville Haines Hibberd Gertrude Janney 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Granville H. Hibberd/ son 3314 Mill Dale La. New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Carroll Cremation, Inc. 1/13/98 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service License 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that cause up to death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each interest. Approximate Interval Between Onset end Death Immediate Cause /Final disease or condition resulting in death) of as e consequence of): Due to (or es a consequence of): Due to (or es e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 □ Yea ZNNg 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

Physician /Medical Examiner ettending physician end for use as the buriel-transit

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After

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after death Director: /

Hospital of 24 hours at Funeral D

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7 is marked other than "natural", or items 23s or 28s-f ahos traumatic event, it a Madical Examinat must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene.
Important: If fem 27 is marked other than "natural", or items 28a and highery or other traumatic event, the Madical Experience once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

with the Maryland

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Physician/Medicai

25. Was case referred to medical examiner?

1 Yes PAN 27. Manner of Death Natural 5 Pending

28e. Dete of injury (Month, Dey Year) investigation

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. injury et Work?

Other: 4☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28d. Describe how Injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

3 ☐ Suicide

4 C Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated.

1 ☐ Yes 2 ☐ No

29b. Signature and title of certified

29c. License number

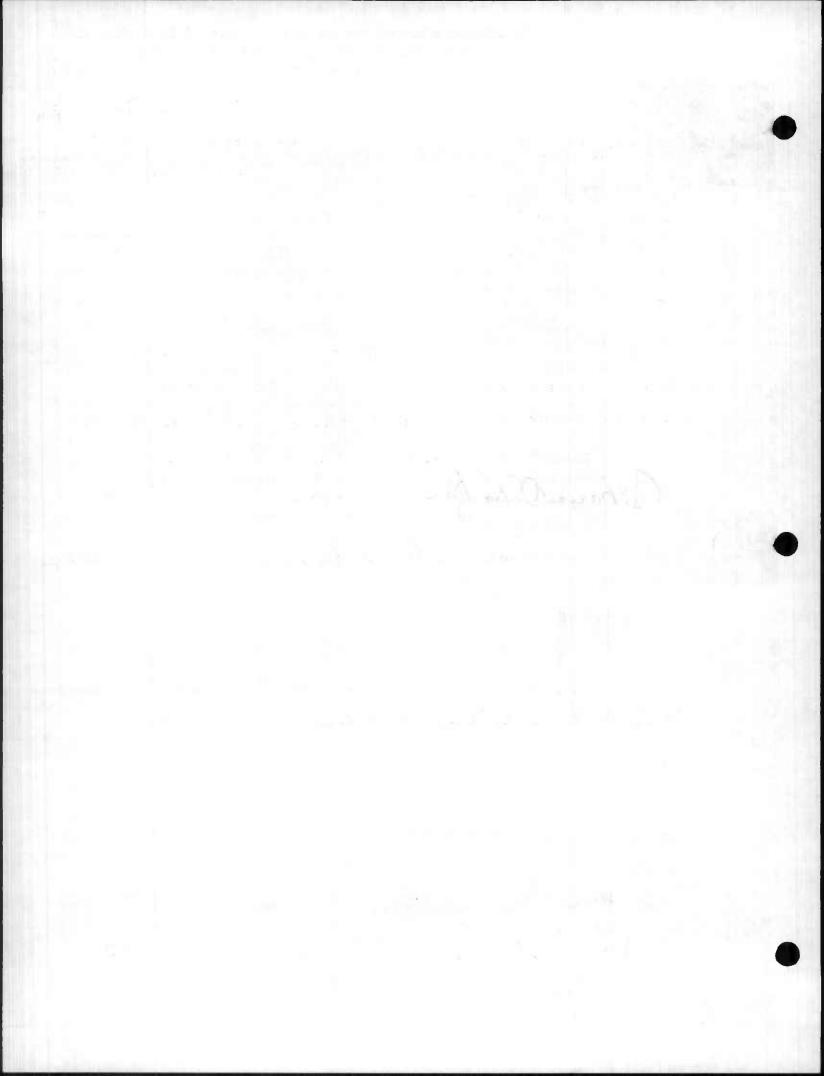
29d. Date signed (Month, Dev. Yeer)

30. Name/and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

State Registrar

104 N. 11 laur ARICOF 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN15



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JESTES 1:35 AM HAZEL JAN 4e. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Dey, Yeer) 10 M 280 F Days Yrs. 408-05-8356 June 15,1915 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Howard Ellicott City 10e, Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4053 Overlook Drive 21043 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes, Sive Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Bleck, White, etc. 11. Maritel Status 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerical Worker Woolen Mill 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Jesse Calvin Mann Sarah McGuire 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) M. Frank Jestes Jr./Son 4054 Overlook Drive Ellicott City, Maryland 21043 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Cemetery 1-13-98 Elkridge, Maryland 22. Name end Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funeral Service Licensee a. alli 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final THEUMONIA 4 DAYS disease or condition resulting in deeth) Due to (or es e consequence of): Due to (or es e consequence of): Due to (or as a consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uee contribute to the cause of deeth? 1 ☐ Yes 2XNo 3 Probably 4 Unknown INTRACRAMIAL HEMATOMA 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE performed'

Physiclan /Medical Examiner

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physician

Department important: if any injury or

Physician

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Examiner

10a. Stete

Funeral

Director

ms 23a or 28a-f short mast be notified at

r than "natural", or items the Medical Examiner ma

I Hygiene.

Pages 1 and 2 should be filed w tment of Health end Mental Hygier tant: if item 27 is marked other th jury or other traumatic event,

Director

Funeral

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Be

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filed within 72 hours after

21215-0020

Baltimore, Maryland

the burial-transit USB BS in by the funeral

The law requires that the death certificate be executed

Box 68760,

P.O.

Records,

of Vital

Division

or Attending Physician:

To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A

completely

After this

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest 25. Wes case referred to medical

29a. Certifier

(Check only

Physician/Medical þ Completed Be Certification: To

PARKINSONS DISEASE,

1 Yes 2 No 26. Piece of Death (Check only one)

1 ☐ Yes 2 ☐ No

1□ Yes 2X	No	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3□ (DOA Other:	4 ☐ Nursing H	Home 5 Residence 6 Other (Specify)
7. Manner of Deeth 1 Neturel 2 Accident	5 Pending investigation	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury et Work?		28d. Describe how Injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Plece of Injury - At building, etc. (Spec	home, farm, stree	t, fact	ory, office		28f. Location (Street and Number or Rural Route Number City or Town, State)

4 Homicide building, etc. (Specify)

12 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier J. Gellers and 29c. License number 038296 29d. Date signed (Month, Dey, Year) BPP1, 11 UAT

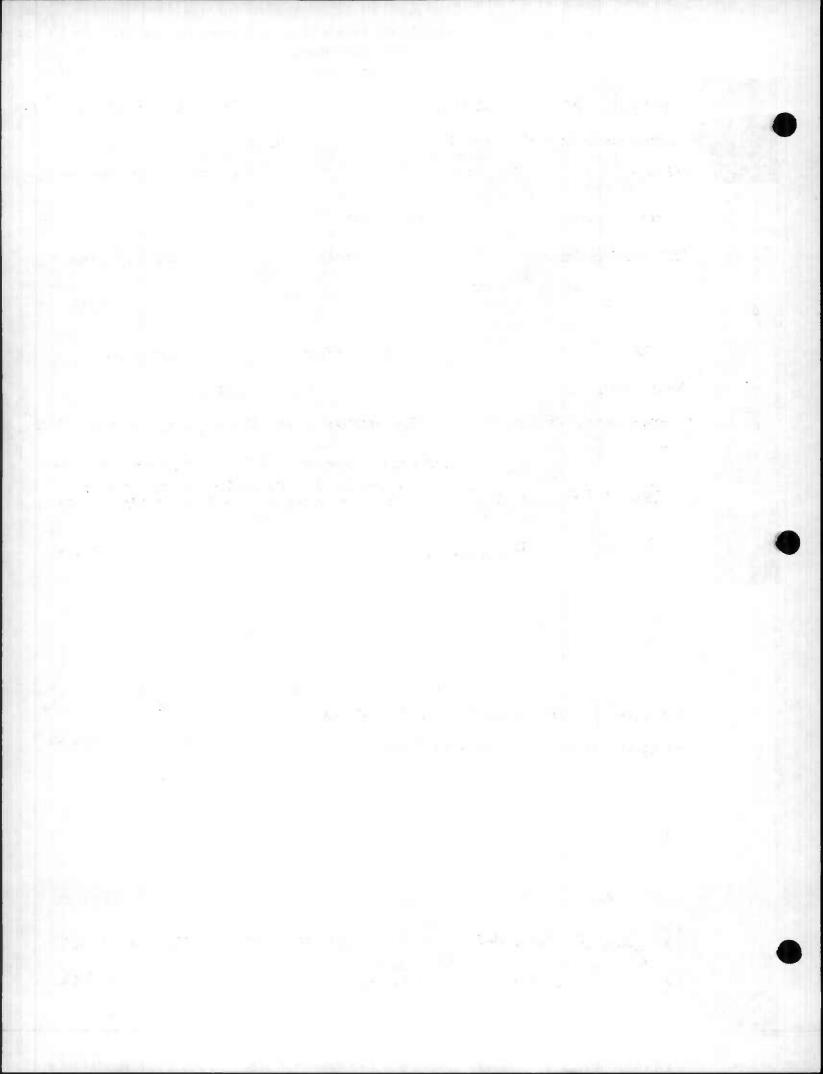
30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

9501 OLD LUNAPOLIS RD, ELLICOTT CITY, MB 21042 JOSEPH F. GIBBONS, MD 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

State Registrar

Medical

Jalia Davideor Rendall



State of Maryland / Department of Health and Mental Hygiene

				Cei	rtificate of		inorman riy	Reg. No.	02314
Physic /Med		Decedent's Name (First, Middle, Last JOANNE M. JOHNSON					2. Date of Dea Month NUARY	Dey 16 19	120.00
Exam	iner	4a. Facility Neme (If not institution, given CHARLES COUNTY NUI	William Careers of			4b. City, Town, or LaPlata		111111111111111111111111111111111111111	of Death rles
Funera Directo		5. Social Security Number 6. S.	9x 7. Age (In yr.	s. last birthday) 76 Yrs.	If Under 1 Year Months Deys		8. Date of Birt (Month, Da) July 1	h v. Year)	Birthplace (State or Fore Country) PA
Maryland -f show	tor	10e. State 10b. County MD Charle		City, Town or Lo aPlata					10d. Inside City Llm
th with the 23s or 28s	Funeral Director	10e. Street end Number 10297 LaPlata F	Rd.		10f. Zip Code 206	546		10g. Citizen of V	Vhat Country?
5-0020 72 hours efter death with the Manjand natural; or Items 23a or 28a-f show fisal Examiner must be notified at	þ	11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:	1	Was Decedent of Inf Yes, specify Cub	dispenic Origin? (Span, Mexican, Puerlo Specify:	pecify Yes or No- Ricen, etc.)	14. Race Blace Specify	a - American Indien, k, White, etc. : White
within than	Completed	15. Decedent's Ed (Specify only highest grader) Elementery/Secondery (0-12)	ucetion de completed) College (1-4or 5+)	(Give life. I	dent's Usual Occup kind of work done DO NOT use retire	during most of world)	king	16b. Kind of Bu	Home
be file the Hy doth	Be	17. Fether's Neme (First, Middle, Last) Paul Milash		17	omemake	18. Mother's Nam	e (First, Middle,	<i>Maiden Sum</i> am	Θ)
aryla should and Men s marke	5	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street	and Number or Ru			
NOFE, ges 1 er if item? or other		Frederick Johns 20a. Method of Disposition 1 Burial 2 12 Cremation 3 Burial 2 12 Other (Specify	Romoval from State	comotory, crom	itatory or other pre	00)			46 City or Town, Stete ndria, VA
Baltimo permit. Pege Department of Important: If any Injury or		21. Signature of Funeral Service been	800 W/ /	A A	Name and Addre	ECHOLS 567 La	FUNERA	L HOME	.PA
box 68 /60, asth certificate be executed Ex Manual	Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	o Dic	diac (or es a conseq (i) or es e conseq (or es e conseq (i) or as a conseq		the			Onset and Death
d by the	Physician	Part II. Other eignificant conditions co	ntributing to death but not re	esulting In the ur	nderlyIng ceuse giv	ven in Part I.			stribute to the cause of deat
requir	Completed by	Asthma					24a. Wes a perfor		24b. Were autopsy finding: avellable prior to completion of cause of death?
ysician: The law s certificate hes director, page 2	Com						1 🗆 Y	es 20 No	1 ☐ Yes 2 ☐ No
Physician: The Physician: The Physician The) Be	25. Was cese referred to medical examiner?	Hospital:		Oth	28. Place of Deal			
nding Phys ath. r: After this	ation: To	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur	4 Lacivursing m	ome 5 Resid		
To the Hospital or Attending Physicial 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre	eet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,
the Hosp in 24 hou the Funer	ledicai	one) 2 Medicat Exam	alclan: To the best of my kn ner: On the basis of examin end manner stated.	owledge, deeth ation and/or Inv	restigation, in my o	pinion, death occur	and due to the d red at the time, o	ause(s) and ma late and place, e	nner as stated. and due to the cause(s)
To t To t	X	29b. Signature and title of certifier	att		D 1	2587	7	1-10	(Month, Day, Year) 7 - 98
Lak		30. Name and eddress of person who comes and self-self-self-self-self-self-self-self-			Print) CENTE	ERWA	LDOR	F, MD.	21062
St	ate		1000: N		0				



98-0091-033

	R.				Certifica	te of l	Death		Reg. No.	0 6 0	
Physicia	n	Nama (First, Middla, L						2. Dete of Dec Month	eth Day	Yaar	. Time of Death
/Medica	HUPEI		ALOYSIU	S	JOHNS		JR •	JANUARY			9:36P.M.
Examine			iva straat and number)			1			12.0		200
Funeral	5. Sociel Secur		D HOSPITAL Sax 7. Ag	a (in yrs. lest bir		ar 1 Yaar	CLINTO	8. Dete of Birt (Month, De	PRINCE		Stete or Foreign
Director The 23a or 28a-f ahow Three be not the market at the control of the co	578-38	B-1829 ce of Decedent	1 ½ M 2□ F	68	Yrs. Month	Days	Hours Min.	10-5-			IGTON, D
ahow	10a. Stete	10b. County		10c. City, Tow	n or Location						Inside City Limits
	B MD	PRINCE	GEORGES	UPPE	R MAI	LBOR	80				1 Yes 2 □ No
	MD 10e. Street end				10f. 2	ip Code			10g. Citizen of W	het Country	
	1070	7 BROOK	VOOD AVE	NUE		2077	72		U.	S.A.	
		tus Married 2 17 M arried	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give		If Yas, sp	edent of H ecify Cuba	ispenic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, atc.)	Black	- Amarican k, White, etc.	
		ed 4 Divorcad	Yaar or Detas:	53-55	10 163	201110	Specify.		Specify:	BLA	CK
Dical	o to	15. Decedent's Specify only highest g		16e.	Decedent's Us	uel Occup	ation during most of work f)	ing	16b. Kind of Bu	siness/Indus	ry
I've Me	-	Secondary (0-12)	College (1-4or	E'	VIDENC		LERK		U.S. DI	EPART MERCE	
₹ ·	17. Fathar's Na	ama (First, Middla, La	st)		The state of		18. Mother's Nem	e (First, Middle,	Maiden Sumami	e)	
marked matic ev	HUPE	ERT	ALOYSIUS	S JOHI	NSON,	SR.	EVA		W:	ILBUR	
and Mentel is marked c	19a. Informen	's Neme/Relationship	(Type, Print)	19b	. Mailing Addre	ss (Street	and Number or Rui	re / Route Numbe	er, City or Town,	State, Zip Co	de) 20772
parmit. Pages 1 a Department of Her Important: If fern any Injury or othe ance.	4 □ Donat	ion 5 □ Other (Spec	10/	ARLII	TAYL 1722	CEME and Addres OR'S NOR	TERY 1 ss of Fecility FUNER TH CAPI	AL HO	ME NW	WASH.	VIRGINI DC_2000
/sician			polication that edusar y one ceuse on eech li	tha deeth. Do ne.	not enter the m			1	rrast,	A	proximate ervat Between nset and Deeth
edical miner	tmmediate Ca disease or cor resulting in de	ndition	· Pula	Due to des e	This		entohas	~			
	2				consequence o						
	Sequentielty life eny, teading cause. Enter Cause (Disease	se or Injury	b	Due to (or es a		f):					
		se or Injury vents	c		consequence o	f): f):					
d by the ettending physicie leteched for use as the bur	Cause (Disease that initiated a resulting in de	se or Injury vents ath) Last	c	Due to (or es a	consequence o	i): i):		23b. Did		ntribute to th	e cause of death? ly 4 XUnknown
igned by the ettending physicie be deteched for use as the bur	Cause (Diseast that initialed a resulting in de	se or Injury vents ath) Last	c	Due to (or es a	consequence o	i): i):		23b. Did 1 □		3 Probat	eutopsy findings ble prior to letion of cause
hes been signed by the ettending physicie ge 2 should be deteched for use as the bur	Cause (Diseast that initialed a resulting in de	se or Injury vents ath) Last	c	Due to (or es a	consequence o	i): i):		23b. Did 1 □ 24e. Was perfo	Yes 2□ No en eutopsy	3 Probate 24b. Wera eveile comp of dec	eutopsy findings ble prior to letion of cause
hes been signed by the ettending physicie ge 2 should be deteched for use as the bur	Cause (Diseast that initiated a resulting in de resulting in de Pert II. Other s	se or Injury vents ath) Last	c	Due to (or es a	consequence o	i): i):	en in Pert I.	23b. Did 1 □ 24e. Was perfo	Yes 2□ No en eutopsy rmed? Yas 2□ No	3 Probate 24b. Wera eveile comp of dec	eutopsy findings ble prior to etion of cause th?
s certificate has been signed by the ettending physicie director, page 2 should be deteched for use as the bur	Cause (Diseas that initiated a resulting in de	ee or injury vents ath) Last Ignificent conditional referred to medical	c d contributing to death b	Due to (or as a due to (or a))))))))))))))))))))))))))))))))))))	consequence of	i): i): cause giv	en in Pert I. 26. Place of Dee	23b. Did 1 □ 24e. Was perfo	Yes 2□ No en eutopsy rmed? Yas 2□ No	24b. Wera eveile comp of det	eutopsy findings ble prior to etion of cause th?

To the Hospital or Attending P within 24 hours effer death.

To the Funeral Director: After t completely filled in by the funeral

Medicai Certification

Natural
Accident 5 Pending investigation

6 Could not be determined 4 Homicide

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier

29e. Certifier (Check only one)

29c. License number

29d. Date signed (Month, Day, Yeer)

20. Name and address of person who completed cause of both (Item 23e) (Type, Print)

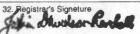
O.C.M.E.

JANUARY 7,1998

THEOONEM, KING 31. Dete filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar



100 A. Section of

Dhusia		1. Decedent's Neme (First, Middle,	Last)				Death	2. Dete of De		3.	Time of Death
Physic		Fannie M. Jame	C					Month	Dey	Year	:20 A.M.
/Medi Exami		4e. Fecility Neme (If not institution,)	<u></u>		4b. City, Town, or I	JANUAR Location of Deet			: 20 A.M.
Exami		MALCOLM GROW ME	DICAL CENT	ER			CAMP SPRI	NGS	PRINCE	E GEORG	E'S
Funeral		5. Sociel Security Number	5. Sex 7. A	ge (In yrs. lest birt	Months	1 Yeer Devs	If Under 24 Hrs. Hours Min.	8. Dafe of Bir (Month, De	th v. Year)	9. Birthplace	(Stete or Foreign
Director		429-22-6510 Usuel Residence of Decedent	IUM ZUF	82	Yrs.			4/24		Arkai	
/land		10e. Stete 10b. County		10c. City, Town	or Location					10d. ir	side City Limits
death with the Maryland ms 23a or 28a-f show must be notified at	tor	MD PG		Templ	le Hills					1	Yes 2□No
or 28	Director	10e. Street end Number			10f. Zip	Code			10g. Citizen of	Whef Country?	
ath w		5814 Center Di					748			USA	
	Funeral	11. Meritel Stetus	12. Wes Deceden Armed Forces	?	13. Wes Decede	ent of H ify Cubi	lispenic Origin? (S en, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Red Ble	e - American In ck, White, etc.	dlen,
"natural", or items 23a or 28a-f show edical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Marrie 3 🖾 Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 🔯 If Yes, Give Yeer or Detes:	No	1□ Yes 2	.□¥o	Specify:		Specifi	. Blac	k
COL E	pe	15. Decedent's	Education	16a.	Decedent's Usuel	I Occup	ation	100	16b. Kind of B	usiness/Industr	,
Med	Completed	(Specify only highest Elementery/Secondery (0-12)	grade completed) College (1-4or	5+)	(Give kind of work life. DO NOT use	k done e retired	during most of world)	king			
ther than	Con	4th		,	House	ewif	e		Privat	е	
d oth	Be	17. Fefher's Neme (First, Middle, La	ast)				18. Mother's Nen		, Maiden Surnan	70)	
marke matic	2	Unknown					Unknow				
Department of neetin and Mental hygiene. Important: if Itam 27 is marked other than "natur any injury or other traumetic event, the Medical once.		19e. Informent's Neme/Relationship		19b.			end Number or Ru				9)
am 27 other tr		Helen Wood Evans 20e. Method of Disposition	/Daugnter	20b. Pleca of	Disposition (Nem	e of	r Drive,T	'emple H		20748 City or Town, 5	Stete
important: if it any injury or o		1 ☑ Buriai 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spe		cameter	y, cremetory or of 19ton Nat	her nier	al Cem		Arlingt		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ortan injur		21. Signature of Fueeral Service Lie	Monteson	4.	22. Neme end	d Addre	ss of Fecility Ro		_		
any is		1 That H	01/4	#	1661	hoof	Hope Rd	SE Was	Mason F	uneral	Home
		23a. Pert1. Enter the diseese, or co shock, or heert feilure. List or	omplications that cause	d the deeth. Do n						App	roximate
sician		Shock, or neert fellure. List of	ily one ceuse on each	ine.						Inte	vel Between et end Death
edical miner		Immediate Ceuse (Fine) disease or condition	RENAL	FAILURE						2 D	AYS
IIIICI	_	resulting in deeth)	.	Due to (or es e o	consequenca of):						
nsit	Examiner		b. METAST		1	NCE	R, END-SI	TAGE		4 Y	EARS
al-tra	Exar	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury		Due fo (or es e c	onsequenca of):						
shysicien end the burial-transit	dicail	tuer surrect exemits	C	Due to (or es e c	oncoming of:						
phys s the	led	resulting in deeth) Lest		Due to (or es e c	onsequence or).					1	
2	any		d							1	
r usa		Part II Other steptificant conditions	contributing to deeth I	out not resulting in	the underlying ca	use giv	en in Pert I.	23b. Did	tobacco use co	ntribute to the	cause of death
ha attending hed for usa	Sic	Pert II. Other significant conditions							Yes 2□No	3 Probably	4 📉 Unknow
ru by the attending deteched for usa (Physician/Med	rent ii. Other significant conditions						1 🗆			
signed by the attending plid be deteched for use as t	by	Pet II. Other significant conditions								24h Ware as	toney findings
been signed by the should be deteched	by	Pet II. Other significant conditions						24e. Wes	en eutopey ormed?	complet	utopsy findings e prior to ion of cause
has been signed by tha ga 2 should be deteched	by	Pet II. Other significant conditions						24e. Wes	en eutopey ormed?	complet of deeth	e prior to ion of cause ?
has been signed by tha ga 2 should be deteched	e Completed by						36 Place of Dog	24e. Wes	en eutopey ormed?	complet	e prior to ion of cause ?
entificata has been signed by tha ector, paga 2 should be deteched	Be Completed by	25. Wes case referred to medical exeminer? 1 □ Yes 2 ☒ No	Hospitel: 1 🛣 Inpatie	ent 2□ER/Out	petient 3□ DO	A Oth	26. Plece of Dee	24e. Wes perfo	en eutopey med? Yes 2/1 No	eveilebli complet of deeth	e prior to ion of cause ?
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Funeral Director: Affar this certificata has been signed by the taly filled in by the funeral director, paga 2 should be deteched	Certification: To Be Completed by	25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Noturel 5 Pending investigal 3 Suicide 6 Could no determine 29a. Certifier (Check only 2 Medical Ex	28e. Dete of Inj. (Month, Distriction and Dete of Inj. (Month, Distriction and Determined 28e. Plece of in building, e	jury - At home, fer to: (Specify) of my knowledge, of examination and	me of jury M 28 m, street, factory, deeth occurred e	3c. Injur Wor 1 office	er: 4 Nursing H yet k? Yes 2 No	24e. Wes performent of the Check only of the Check only of the 28d. Describe 28f. Location (City or To	en eutopey rmed? Yes ② No one) denca 6 Oth how injury occur Street end Numb wn, Stete)	evellebil completed for the service of deeth service (Specify) and service or Rurel Routenner es steted.	e prior to ion of cause ? 2KJ No
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** nous and reader. After this certificate has been signed by the Funeral Director. After this certificate has been signed by the taly filled in by the funeral director, page 2 should be deteched	edical Certification: To Be Completed by	25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Noturel 5 Pending investigal 3 Suicide 6 Could no determine 29a. Certifier (Check only one)	28e. Dete of Inj. (Month, Distriction and Dete of Inj. (Month, Distriction and Determined 28e. Plece of in building, e	jury - At home, fer to: (Specify) of my knowledge, of examination and	ime of signiny M 28 m, street, factory, deeth occurred e Vor Investigetion, 29c.	Bc. Injur Wor 1	er: 4 Nursing H y et k? Yes 2 No ne, dete end pleca pinion, deeth occur e number	24e. Wesperform	en eutopey med? Yes 2 No one) denca 6 Oth how injury occur Street end Numb wn, Stete) ceuse(s) end medete end plece, 29d. Date signe	evellebil complet complet complet of deeth 1 Tyes er (Specify) and the complete comp	e prior to ion of cause ? 2X No site Number, ceuse(s)
24 hours after death. Funeral Director: After this certificate has been signed by the staby filled in by the funeral director, page 2 should be deteched	edical Certification: To Be Completed by	25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Noturel 5 Pending investigal 3 Suicide 6 Could no determine 29a. Certifier (Check only one)	28e. Dete of Injuiding to be ad 28e. Plece of in building, e 28e. Plece of in building, e 28e. Plece of in building, e 28e. Plece of in building, e 28e. Plece of in building, e 28e. Plece of in building, e	uny 28b. T In In In In In In In In In In In In In	m, street, factory, deeth occurred e Vor Investigation, 29c. MD-	3c. injur Wor 1 - office t the tin In my o	er: 4 Nursing H y et k? Yes 2 No ne, dete end pleca pinlon, deeth occur e number 2359-L	24e. Wesperform	en eutopey med? Yes 20 No one) denca 6 Oth how injury occur Street end Numb wn, Stete) ceuse(s) end med dete end plece, 29d. Date signe	er (Specify) red er (Specify) red er or Rurel Rou enner es steted, end due to the d (Month, Dey,	a prior to ion of cause? 2 X No ate Number, ceuse(s) Year)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death **Physician** Month CICELY LILLIAN KIMMELL **JANUARY** 10, 1998 8:45 AM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUPPETT & WEEKS NURSING HOME GARRETT OAKLAND If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplaca (Stata or Foreign **Funeral** 1□M 2XF Days Hours Yrs. 218-34-2028 88 Director JAN 28 1909 MARYLAND Usual Residence of Decedent death with the Merylend 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MD GARRETT Director OAKLAND 1 X Yas 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizan of What Country? 13 W. LIBERTY STREET 21550 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-II Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. permit. Peges 1 end 2 should be filed within 72 hours efter of Depertment of Heelih end Mental Hygiene. Importent: If Item 27 Is merked other than "natural", or item any Injury or other traumetic event, the Medical Exercises. 1 Yas 2 No If Yes, Give Year or Dates: 1 □ Nevar Married 2 □ Married Baltimore. Maryland 21215-0020 1 ☐ Yes 2 X No þ Specify: 3K Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LICENSED PRACTICAL NURSE NURSING 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ERNEST BURGESS GRANT MARGARET LEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARY L. MOON - DAUGHTER P.O. BOX 165 CRUMPTON, MD 21628 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal Irom State 1/13/98 OAKLAND, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) FAIRVIEW CEMETERY 22. Name and Address of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) bacterial endocarditis 2 weeks Examine Due to (or as a consequence of): Examiner 2 weeks septicemia physiclen end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated avents resulting in death) Last Due to (or as a consequence of): Box 68760 group D enterococcus 2 weeks Physician/Medical Dua to (or as a consequence of): diverticulitis 3 weeks 980 ed by the a 0.0 Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown diabetes mellitus þ 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy Completed peed hes certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case raferred to medical examiner?
1 ☐ Yes 2 ☒No director, 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Hospital or Attending 24 hours efter death.
 Funeral Director: After 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Medical 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25759 January 10, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter K. Naumann, M.D., 106 Cemetery Road, Accident MD 21520-0247

DHMH 16 Rev 6/95

State

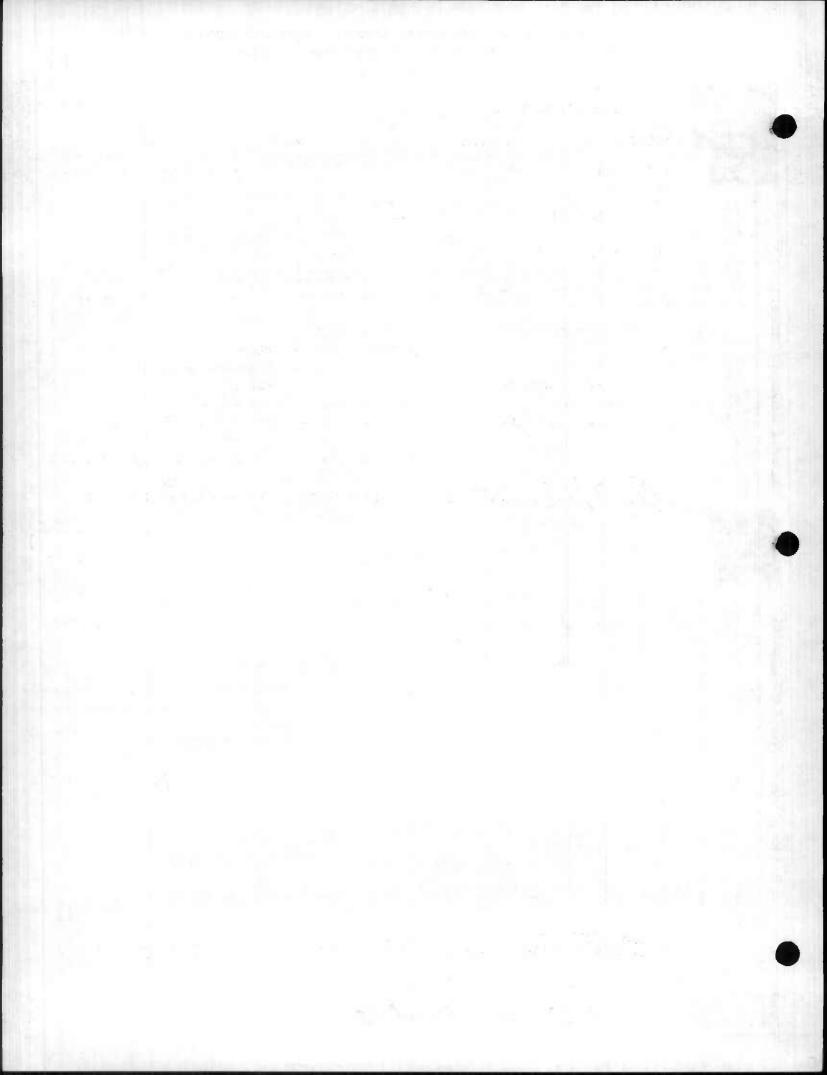
Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

shi Mudeor Real

JAN 1 2 1998 >



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1/13/98, M.W.O., Howard Co. 1. Decedent's Name (First, Middle, Last) 2. Data of Daath Paxine Month **Physician** 0645 197 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give streat and number) Examiner 40me Calambia NUVSIOS LOWGV C Lorien If Under 1 Year if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Ye Dec 22, 1 9. Birthplece (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🕌 F Deys 226-32-5537 70 69 Yrs. Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Director Maryland Howard Dayton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5023 Morning Star Drive 21036 Funeral United States 12. Wes Decedant Evar in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 Yes 2 No it Yes, Give Year or Dates: 1 □ Never Married 2 □ Marriad 1 ☐ Yes 2 X No Specify: by Specify: 3 ☐ Widowed 4X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown Homemaker Own Hame 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 2 unknown Dugger Jamie Davis 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Donna Childers/Daughter 5023 Morning Star Drive Dayton, Maryland 21036 20b. Plece of Disposition (Nema of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 X Cremation 3 ☐ Removal from Stete 4 □ Donetion 5 □ Other (Specify) Balt-Washington Crematory1-11-98 Laurel, Maryland 21. Signature of Funerel Sarvice Licensee 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. Coll 4112 Old Columbia Pike Ellicott City, MD 21043 23e. Pert1. Enter the disease, or complications that caused the daeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intarval Between Onset end Death immadiata Cause (Final disease or condition resulting in deeth) · cardio myopath Examiner artery Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events resulting in deeth) Last Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of causa of deeth? 24a. Was en eutopsy performed? 1 ☐ Yes 2.00 No 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2D No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred

physician and the burial-transit Division of Vital Records, P.O. Box 68760, signed by the atta peen has page 2 certificata To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director; After this certifica funaral director,

Physician /Medicai

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiena. Important: if flam 27 is marked other than "natural", or feather the market any injury or other treumstrand.

Physician/Medical p Completed

Certification: To

State

Registrar

Medical

29b. Signeture and title of certifier

5 Pending Investigation

6 Could not be

29c. Licensa number

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner stated.

1 Yes

2 🗆 No

29d. Data signed (Month, Day, Yeer)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

GRYY KGZ(OWM) 10805 Hick

Hickory Ridge Ref Columbia Md 21044

31. Data filed (Month, Day, Yeer)

1 & Neturel

2 Accident 3 Suicide

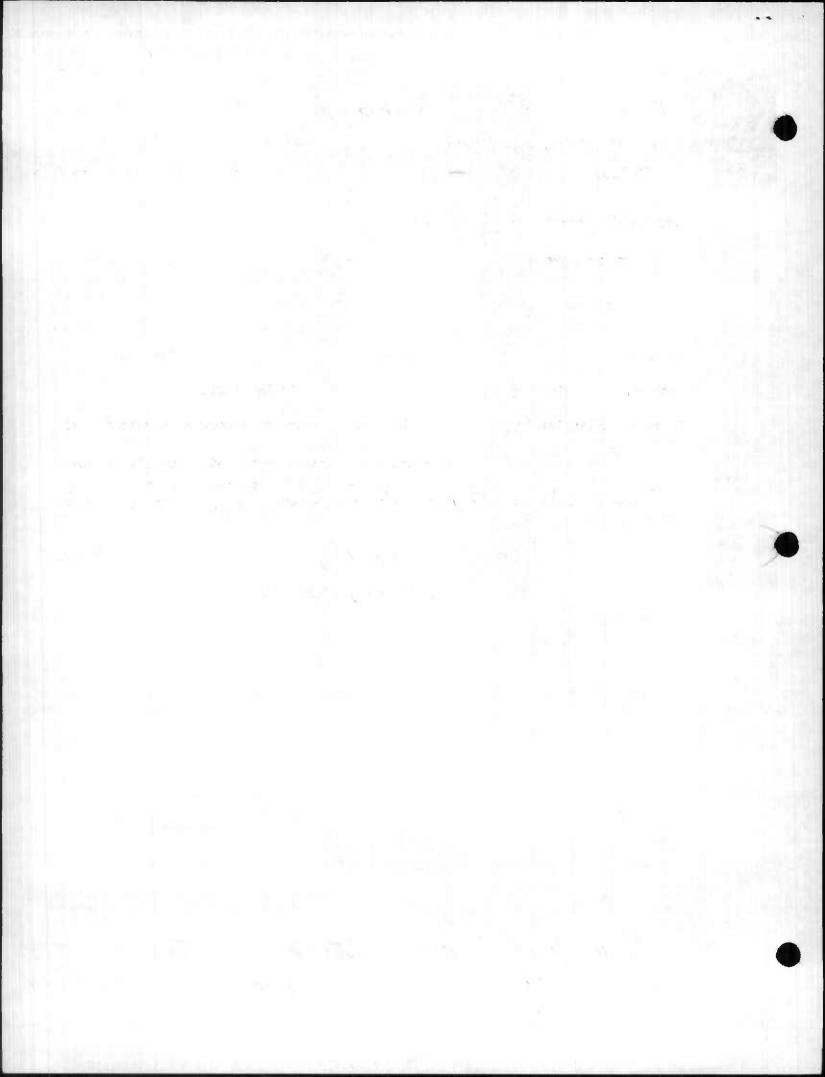
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29a. Certifier

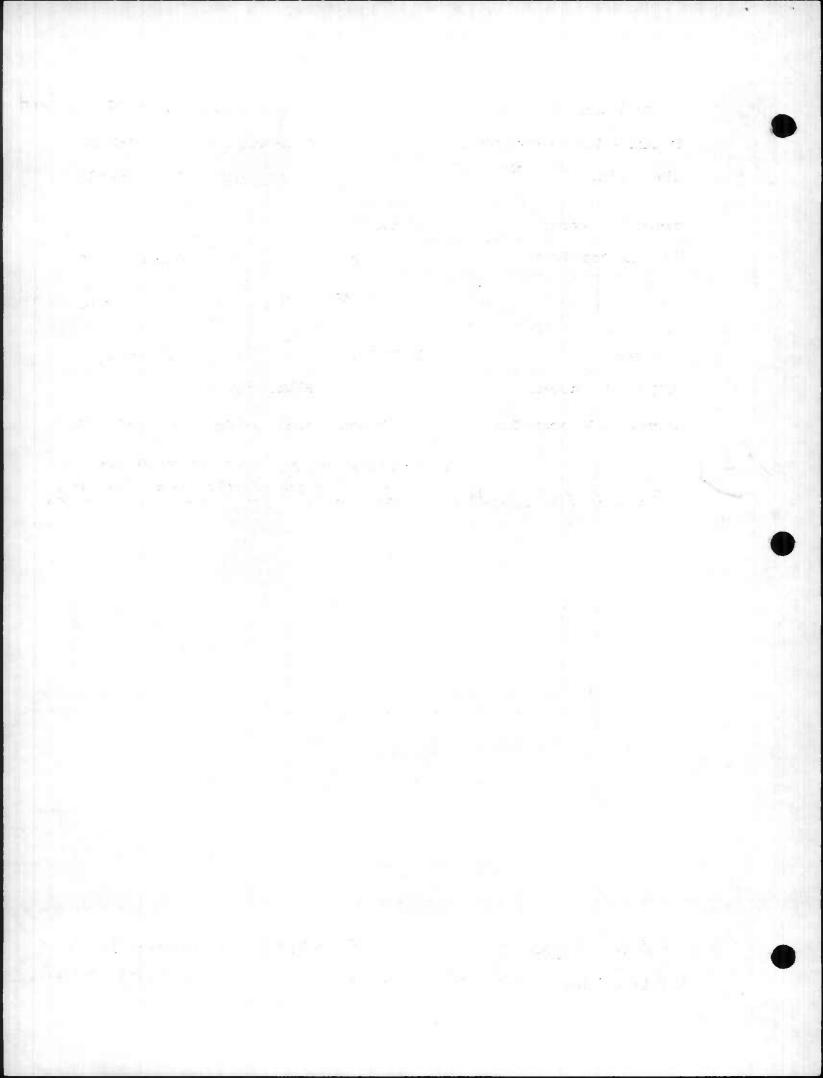
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28e. Plece of Injury - At home, farm, street, tectory, office building, etc. (Specify)

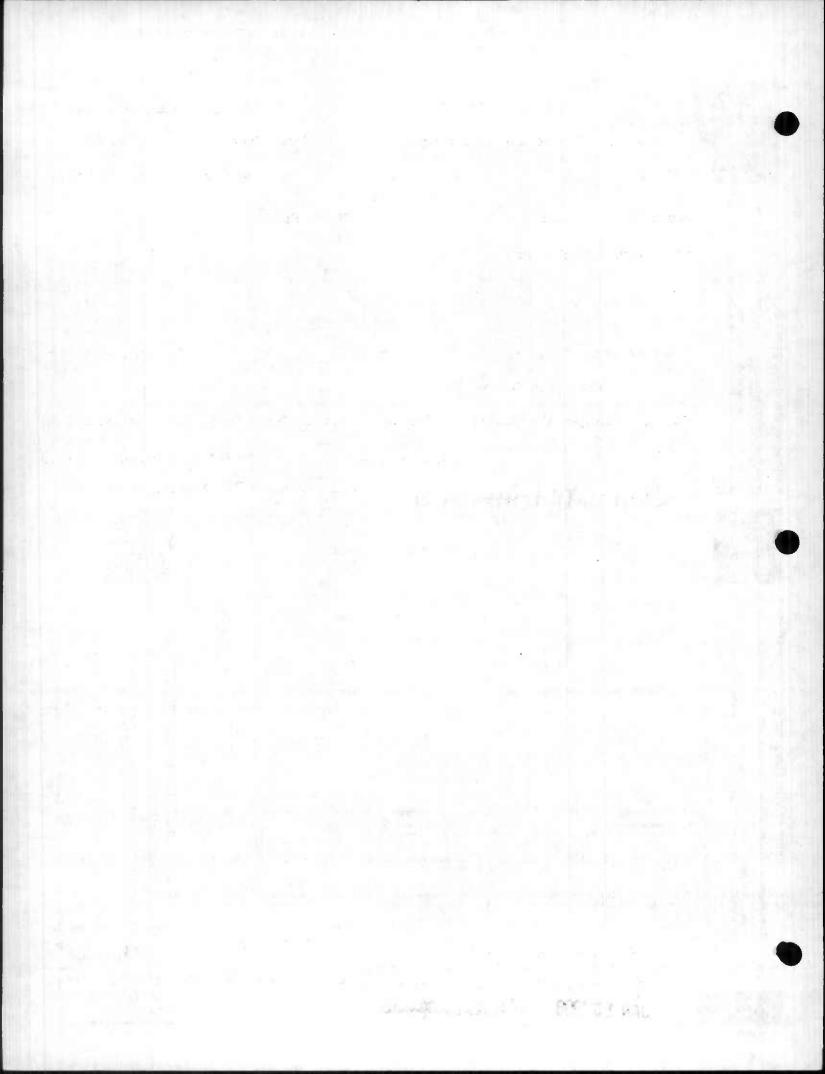


Amended	#	5,01/15/98/,PCT,HOWARD	e of Maryland		tificate of			Reg. No.	02319	
Physicia /Medica	al	Decedent's Neme (First, Middle, Last) Mary Lillian Kefauve				th Oh Town and	2. Deta of Dea Month	Pay 1	110	Death Do Pi
Examine	er	4e. Facility Name (If not institution, give street an				4b. City, Town, or L		4c. County	111 - 75	
Funeral Director		Frederick Villa Nursin 5. Social Security Number 219-40-6962 Usuel Rasidence of Decedent	7. Age (In yrs. la	ast birthday) Yrs.	If Undar 1 Year Months Days	Catonsv: If Undar 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey Apr 2,	Year)	altimore ^{9. Birthplaca} (Stete of Country) Maryland	r Foreig
De de la la la la la la la la la la la la la		10a. Stete 10b. County	10c. City,	, Town or Loc	cation				10d. Inside Cit	y Limits
win / / z nours enter deem with the Meryland than "natural", or itema 23a or 28a-f show he Medical Exercises must be recitied at	Director	Maryland Howard	W.	Voodsta	OCK			10- 011(1	1 □ Yas	2 ⊠ No
T po of		1841 Woodstock Road			21163	2		10g. Citizan of V	States	
jane. r than "naturel", or itema 23a or 28a-f sho the Madical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Merried 2 Married 1 Yes	Decedent Ever in U,S d Forces? 'es 2 2 No e, Give or Datas:	lf	Vas Decedent of F	Hispenic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yas or No- Rican, atc.)	14. Rac	e - American Indian, ck, Whita, etc.	
nd Mentel Hygiene. marked other than "natural", matic svent, the Mad cal Exa	Completed	15. Decedent's Education (Specify only highest grade compla		(Give I life. D	ent's Usuel Occup kind of work dona OO NOT use retired	during most of work	ing		usiness/industry	
od other svent, i	Be C	17. Fether's Nems (First, Middle, Last)		CITIC	Care	18. Mothar's Nam	e (First, Middle,			
Mentel Hygiane. Tarked other than natic svent, the Me	ToB	Benjamin F. Nickels				Ellen La	aird			
		19e. Informent's Neme/Reletionship (Type, Print)		19b. Meilin	g Address (Street	end Number or Rui	al Route Numbe	r, City or Town,	State, Zip Code)	
		Emerson N. Kefauver/Sc				Road Wo			and 21163	
nt: if ite		20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Ramoval f 4 ☐ Donetion 5 ☐ Other (Specify)	rom Stete	m <i>etery, cre</i> m	sition (Neme of letory or other place		Date 1 1 2 0 0		City or Town, Stete	
Department of Health Important: If Item 27 any injury or other to once.		21. Signature of Funerel Service Licensee	at /	St Rei	Neme end Addre	lurch Cem ss of Facility Vitzke's]	1-12-98 Family F	uneral	Home, Inc.	
.D = 6 d		23a. Pert1. Enter tha disease, or complications to	White	41	12 old (Columbia 1	Pike Ell	icott C	City, MD 21	
shysicie the bur	edical Examiner	Immediate Ceuse (Final disease or condition resulting in deeth) Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceusa (Disease or Injury that Initiated events resulting in deeth) Last	Due to (or	as a consequence as a consequence a consequence	uence of):	EARCTION			2 &	7
y the ettending p	Physician/Me	d								
by the	hys	Pert II. Other significant conditions contributing			derlying cause giv	en in Pert i.		obacco use coi 'es 25 No	ntribute to the cause o	
be d	Completed by F	SENTE DEME	L DISEA.	\$6			24a. Was a	an autopsy	24b. Were eutopsy fi aveilable prior to completion of ca of death?	indings
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certificate h	Re	25. Wes casa referred to medical axaminar? Hospital:			Oth	26. Plece of Deet				
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or death. ector: After by the funer	Certification:	1 Neturel 5 Pending 2 Accident investigation 3 Suicida 6 Could not be	Month, Day Year)	212	28c. Injur Wor M 1□	k? Yes 2 € No		MIA.		
s efter death.	Certif	determined 289. P	leca of Injury - At hon uilding, etc. (Specify)	ne, farm, stre	et, fectory, office		28f. Location (S City or Tow	n, Stete)	er or Rural Route Numb	<i>)er</i> ,
	edical	29e. Certifier (Check only one) 1 Certifying Physician: To the decided Examiner: On the and it are the control of the control one)	the best of my knowled basis of examinetic menner steted.	ledge, deeth on end/or inve	occurred et the tir estigetion, in my o	ne, dete end pieca, pinion, deeth occur	end due to the c red et tha time, d	euse(s) end me lete end piece,	enner as steted. and due to the cause(s)	
	Me	29b. Signeture end titie of certifier			D · 3	e number 30469	. 3	29d. Dete signer	d (Month, Day, Year)	18
2		N.B. VELLANKING, 905	cause of deeth (Item 2	23a) (Type, F ROLE						
State Registra		31. Date filed (Month, Day, Year) JAN 1 2 1998	2. Registrar's Signetu							



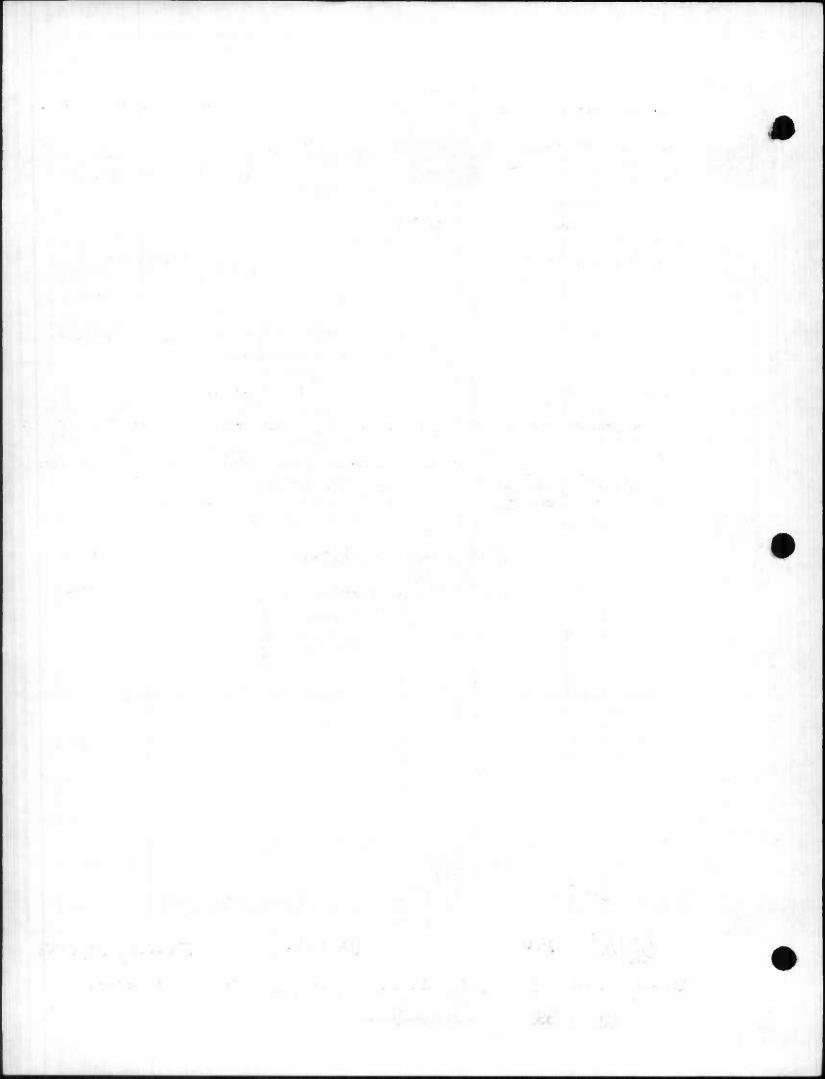
State of Maryland / Department of Health and Mental Hygiene

-		Decedent's Name (First, Middle, La			Certificate	of Death	2, Dete of De	Reg. No.	3. Time of Deat
Physicia		I	isa Joy Kos	smos			Month	Dey	Yeer
/Medica		4a. Fecility Neme (If not institution, giv		31103		4h City Town o	Jan war r Location of Deel		
Examine	er		Bethel Chui	rch Road		North		4c. County	
		5. Social Security Number 6. S		(In yrs. last birth				-th	Cecil
uneral irector			DM OTTE	40 Yr	Months D	eys Hours Mi		3,1957	9. Birthplace (State or Fore Country) Maryland
No m		10e. Slate 10b. County		10c. City, Town	or Location				10d. Inside City Lim
들글 :	to	Maryland Ced	cil		1	North East			1 ☐ Yes 2 🔯
noti	Director	10e. Street end Number			10f. Zip Co	de		10g. Citizen of	Whel Country?
3a o		596 Bethel Church	Road			21901			.S.A.
or items 23s or 28s-f show	Funer	11. Marital Status	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give	er in U,S.		of Hispenic Origin? (Cuban, Mexican, Pue	(Specify Yes or No arto Rican, etc.)	o- 14. Rad Bled	ce - Americen Indian, ck, White, etc.
- A	g S	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		100 20	sto opecny.		Specify	White
the Medical Exami	Completed	15. Decedent's Ec (Specify only highest gree Elementary/Secondary (0-12) Eleven Years	fucetion de completed) College (1-4or 5+)	16e. D	ecedent's Usual C Give kind of work of ife. DO NOT use r Homemal	ccupation one during most of w etired)	orking		usiness/industry
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kad c	To Be	Pete N	ick Kosmos,	Sr.			eggy Jew		
other traumatic		19a. Informent's Neme/Reletionship (Mailing Address /S	treet and Number or I	001		. A
27 Is or trau		Connie S. Draper							Maryland 2190
other	-	20a. Method of Disposition	(companion)				Dete		- City or Town, State
ant: If Ite		XBuriel 2 ☐ Cremetion 3 ☐			isposition (Neme cremetory or othe				
Important: If I any injury or once.		4 ☐ Donetion 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		Asbur	y Cemete	ry ddress of Fecility	1/16/98	Port De	posit, Maryla
vsician ledicai aminer	iner	23e. Part1. Enter the disease, or compshock, or heert failure. List only immediate Ceuse (Finel disease or condition resulting in death)	· Brea		ancer				Approximate Intervel Between Onset and Death
es the buriel-transit	Ical Exam	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury thel Initieted events resulting in deeth) Lest	C	ue to (or es e con					
	апумед	resulting in deeth) Lest	d						
ta ed for	200	Pert II. Other significent conditions co	ontributing to death but r	not resulting in th	ne underlying ceus	e given in Pert I.	23b. Dld	tobacco use co	ntribute to the cause of dec
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houl	nanaidu						24e. Wes	en eutopsy ormed?	24b. Were eutopsy finding eveileble prior to completion of ceuse of death?
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ertific sctor		25. Was cese referred to medical examiner?					eth (Check only	one)	
J dire		TE Tes 200 NO	Hospital: 1 Inpatient	2 ☐ ER/Outpa	atient 3 DOA	Other: 4 Nursing	Home 5 Resi	dence 6 □Oth	er (Specify)
ther the	5 3	27. Manner of Death 1 ☑ Neturel 5 ☐ Pending	28e. Dete of Injury (Month, Dey Y	(ear) 28b, Tim	e of 28c.	Injury et Work?	28d. Describe	how injury occurr	red
br: A	10	2 Accident Investigation			M	1 ☐ Yes 2 ☐ No	F		
To the Funeral Director: After this certificate has b completely filled in by the funeral director, page 2 s Medical Certification: To Be Comple		3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specify)			City or To	wn, State)	er or Rurel Route Number,
pletely fill	2	29e. Certifier 1X Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of n iner: On the basis of ex	raminetion end/o	eeth occurred et the rinvestigetion, in r	e time, date end pled ny opinion, death occ	e, and due to the urred et the time,	cause(s) and me	enner es stated. and due to the ceuse(s)
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28	1	29b. Signature and Iftle of certifier	1			cense number	, , ,		d (Month, Dey, Year)
		1 / tar	Mas 1	1)	レン	1531	14	Jan	13, 1998 Ikton, Mi
	1	IO. Name and eddress of person who o	ompieted cause of deet	th (Item 23a) (Ty	pe, Print)	,	/		./
		It Furkes,	no VN	1/ N.	Then	Chesusea	pe Hosp	ice, E.	Ikton Mi
State		31. Dete filed (Month, Day, Year)	39. Registrar's		2.00				
Registrar		17/1 1 9 1220	Culton Jan	MANA-MONO	14.104a				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

					Certific	cate of	Death		Reg. No.	0%	721
Physici	ian	Decedant's Nama (First, Middle, La	st)					2. Data of I		Year	3. Tima of Death
/Medic		Evelyn Prestor	-					Janua	ry 18 1	998	10:45 PM
Examir	ner	4a. Facility Name (If not institution, give	e street end number)				4b. City, Town, o	r Location of Dea	ath 4c. Coun	ty of Death	
Funeral Director		212-38-4296		enter a (In yrs. last 89		Inder 1 Year oths Days		n. 8. Dete of E	Cec Birth Day, Year) 12, 1908	9. Birthple Countr	aca (Stata or Foraign y) y land
pu s		Usual Rasidance of Decedant 10e. Stata 10b. County		10c City T	own or Location					10	d Inside Obstina
e Menyla	ctor	Maryland Cec	il		sing Sur					10	d. Insida City Limits 1 ☐ Yas 2 ☒ No
\$ 9 P	Dire	10e. Street and Number			10	f. Zip Code			10g. Citizan of	What Countr	JY?
1 23a	ral	1881 Telegraph R					21911			State	
permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Menyland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Timportant: If team 27 is marked other than "returef, or items 23s or 23s-f show any injury or other traumatic event, the Medical Exerciting mant be notified at once.	by Funeral Director	11. Maritel Status 1 ☐ Navar Marrled 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Wes Dacedant E Armed Forcas? 1 ☐ Yas 2 ☒ N If Yas, Giva Yaar or Dates:				Hispanic Origin? ben, Maxican, Pus Specify:	(Specify Yes or Narto Rican, etc.)		eca - America ack, White, e ify: Wh	
72 ho	Completed	15. Decedent's Ed (Specify only highast gra	ducation	1	6e. Decedant's	Usual Occu	pation	ndrina	16b. Kind of	Businass/Indu	ustry
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3 Mer marke	To	Walter R. Presto						nina Jon			
12 sr h and r la n traur		19a. tnformant's Name/Ralationship (t and Number or I				
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nt of nt of nt of		1 ☑ Buriel 2 ☐ Cramation 3 ☐		cama	atary, cramatory	or other pla		Jan. 22	2		
it. P		4 Donation 5 Other (Specifical Service Licet		Nort	h East		ist Cem.	1998	North I	East, N	Maryland
Depari Impor		1488E	el		Crou	ch Fur	neral Hor Main Sti		orth Eas	t, MD	21901
Physician		23a. Part1. Enter the diseesa, or com shock, or haart failure. List only	plicetions thet caused ona causa on each lin	the daath. I							Approximeta Intarval Between Onset end Death
/Medical Examiner		Immediata Cause (Final diseasa or condition	End	Sta	n A	Izhei	Acr				fewi
Exammer		rasulting in daath)	b. End	Dua to (or as	consequance	of):					Peur
D #5	ine		B-J	· 5+.	my P	whi	اسمار				Teur
cate be axecuted physician and the burial-transit	i Examiner	Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated events		Dua to (or es	aconsaquance	of):				1	
rtificate of physic es the b	Medical	that initiated events rasulting in death) Last		Dua to (or es	e consequance	of):				i	
leath certific attending pl	Physician/		d							1	
that the de ed by the detached	ysic	Pert II. Other significant conditions of	ontributing to death bu	t not rasuitin	g in the underly	ing cause g	iven in Pert I.				the cause of death?
signed by	by Ph							_ 1[Yes 2010	3 Probe	ably 4 Unknown
been shoul	Completed b							24a. Wa	as an autopsy rformed?	avai	a autopsy findings labia prior to plation of cause aath?
0 - 0	mo							10	Yas 200 No	- 10	Yas 20 No
	0	25. Was cesa refarred to medicel					26. Place of D	eath (Check only			
Physician: this certific ral director,	To B	axaminar? 1 ☐ Yas 2 ☐ No	Hospital:	t 2 ER	Outpetient 3D	DOA O	har:		sidance 8 🗆 O	thar (Specify)	
Affer fune		27. Manner of Daath 1 Natural 5 □ Panding 2 □ Accident Invastigation	28a. Data of Injury (Month, Day	/ 28	b. Tima of Injury	28c. Inju		_	e how injury occu		
tal or Attending rs after death. at Director: After ed in by the fune	Certification:	3 Sulcida 6 Could not be datarmined		ry - At homa (Specify)	, farm, street, fa				(Street and Nun own, Stata)	nber or Rural	Routa Number,
vithin 24 hours at Yo the Funeral DI completely filled in	edical	29a. Cartifiar (Check only 2 ☐ Medicat Exam	yalctan: To the bast of alner: On the basis of alner state	axamination	iga, daath occu and/or invastiga	rred at tha t ation, In my	ima, data and plac opinion, daath oc	ce, and dua to the	a causa(s) and n a, data and place	nannar as sta , and dua to t	ited. tha causa(s)
within 2 To the comple	Me	29b. Signature and title of certifier				29c. Lican	se number		29d. Date sign	ed (Month, D	ay, Year)
- 5 - 0		> (Mh)	10			04-	1711				
									-	/	1
g		30. Name end addrass of person who	complated cause of da	ath (Itam 23	a) (Type, Print)		1711 th Engl		4		



State of Maryland / Department of Health and Mental Hygiene 9 8 0 2 3 2 2

			Cei	tificate of	Deam		Reg. No.	O L O L L
Physician /Medical	Decedent's Name (First, Middle, La Lawrence	e George	Kistle	r. Jr.		2. Data of D Month Jan	Dey 12. 1998	3. Time of Death 10:15 A.M
Examiner	4a. Fecility Name (If not Institution, giv	e street and number)			4b. City, Town, or I		,	of Deeth e George's
Funeral Director	328 Winslow Roa 5. Sociel Security Number 6. S		yrs. lest birthday) 74 Yrs.	If Under 1 Year Months Days		8. Date of Bi	irth (9y, Year) 2. 1923	9. Birthplace (Stete or Foreign Country) Minnesota
	Usual Residence of Decedent		74			pct. 22	2, 1723	Hillinesota
illed with 12 hours enter death with the Meryland ther then "natural", or items 23a or 28a-f show but, the Medical Examiner must be notified at completed by Funeral Director	10a. Stete 10b. County Maryland Prince G		o. City, Town or Lo Oxon Hil					10d. Inside City Limits 1 ☐ Yes 2 🖾 No
or 28a-february	10e. Street and Number			10f. Zip Code			10g. Citizen of 1	What Country?
23a or	328 Winslow Road			20745				S.A.
it, or thems 23a examiner munit	11. Maritel Status 1 Never Married 2 Married	12. Wes Decedent Ever Armed Forces? 1 1 Yes 2 1 No. If Yes, Give 1950 Year or Dates:	In U,S. 13. 1		Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or N o Rican, etc.)	o- 14. Rad Blee	a - American Indien, ck, White, etc.
"natural", ndcal Ex-	3 Widowed 4 □ Divorced							
tal Hygiene. d other then "natural went, the Medical I. Be Completed	15. Decedent's Ec (Specify only highest gra Elementery/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give		petion during most of wor ed)	king		usiness/industry
Hygiene. ont, in w	12 17. Fathar's Nama (First, Middle, Last)		Alr	Force	19 Mother's Nam	no /Eiret Middle	Mili e, Malden Sumen	
B S B								10)
ond Mental Hygie marked other t umatic event, to To Be Co	Lawrence George K					ia Blakı		
27 le	19a. Informant's Name/Relationship (Vicky Ann McMorri	s/Daughter	328	Winslow	Road, Oxo			
nent of Hee int: If Item irry or othe	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removel from Stata	Ob. Place of Dispo cametery, crer letropoli	natory or other pla		Date /13/98		City or Town, State
Departm Importa any Inju	21. Signature Funeral Servica Licen		A Ge	Name and Address P.		neral H	ome	
nysician	23a. Part1. Enter the duese, or companded, or heart fallus. List only	plications that caused the one ceuse on each line.	death. Do not anti	er tha mode of dyl	Ing, such es cardiac	or raspiratory	arrest,	Approximate Interval Between Onset end Death
/Medical xaminer	Immediate Cause (Final disease or condition resulting in death)	e	425 to (or as a conseq	uones of):				6months 224 hrs
n end ial-transit		b. V	entila	tory f	Failure			
physicien end s the burial-transit	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury	Due C.	Disphi	agmak	ailure E Failu	ure		< 24 hrs.
nding physicien and use es the bunial-transin/Medical Exami	thet initieted events resulting in deeth) Lest	Due	to (or as a conseq	uence of):				
ad by the ette deteched for Physicia	Part II. Other algnificant conditions co	ontributing to death but no	t resulting in the ur	nderlying cause gi	ven in Pert I.	23b. Did	tobacco use co	ntribute to the cause of death?
igned by the etter be deteched for the by Physician	Hype	ostensin				10	Yes 2□ No	3 □ Probably 4 Unknow
should should	701	bacco use				24e. Was	s en eutopsy ormed?	24b. Were eutopsy findings evailable prior to complation of causa of deeth?
E 2 E						1□	Yes 2 No	1 ☐ Yes 2 No
certificate rector, peg	25. Was case referred to medical				26. Placa of Dea			74.10
his certific il director, To Be	examiner?	Hospitel: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Ot		11	idenca 6 Oth	ns (Gnasibi)
After thi funeral	27. Manner of Deeth 1 Naturel 5 Pending 2 Accident Invastigation	28a. Date of Injury (Month, Day Yea	28b. Time of	28c. Inju Wo			how injury occur	
rs after deeth. al Director: After t ed in by the funera Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - building, etc. (Sp	At home, farm, stropecify)	eet, factory, office			(Street and Numb own, Stete)	per or Rural Routa Number,
tuner funer ely fill	29a. Certifier (Check only one) Certifying Phy	ysicien: To the best of my niner: On the basis of exar end menner steted.	knowledge, deeth ninetion end/or inv	occurred at the ti restigetion, In my	me, dete end plece opinion, deeth occu	, end due to the rred at the time	ceuse(s) end ma , date and place,	anner es steted. and due to the ceuse(s)
within 2 To the Complet	29b. Signature and title of cartifier	Primary	areshy:	29c. Licen:	se number VA 0/0/05	2835	29d. Date signe	d (Month, Day, Year) 12-98. nd/ews Afbir 20762
0)	30. Name end eddress of person who c	completed cause of death meer Ahm	(Item 23e) (Type,	Print) SGOEP	MGMC	60147	eam A	ndiens Afbit 20762
State Registrar	31. Date filed (Month, Day, Year)	32 Registrar's S	ignature P	t				



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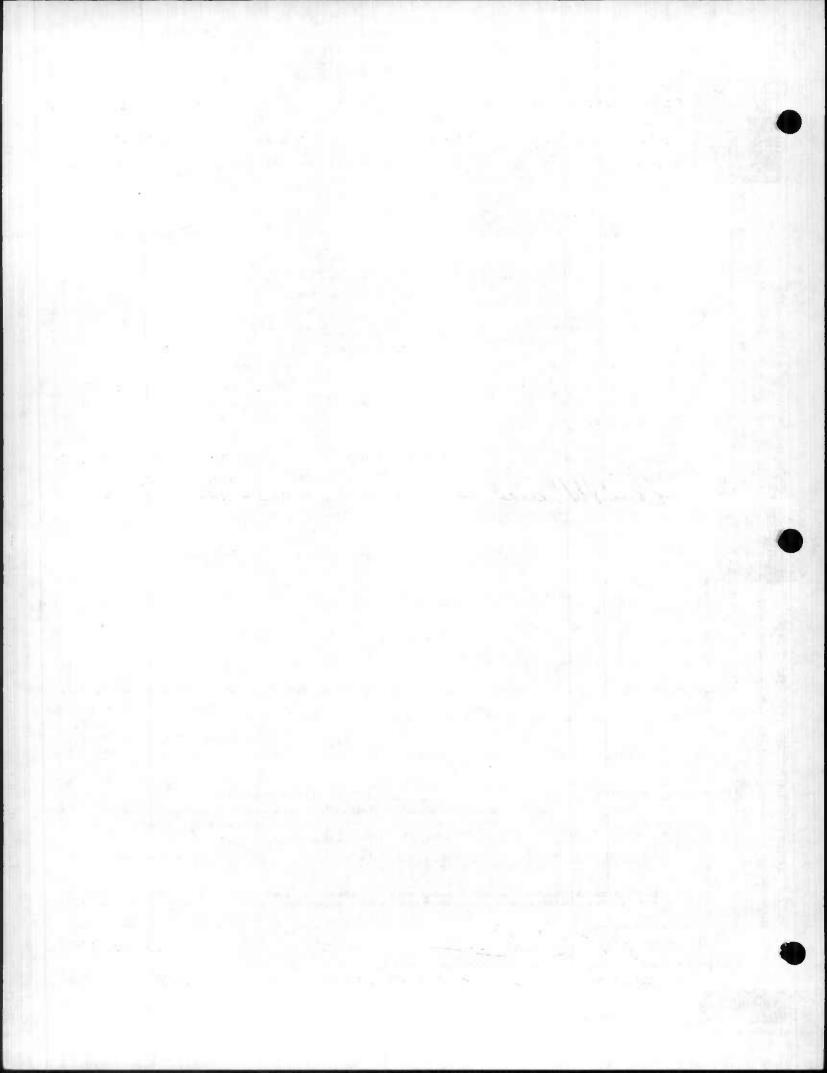
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** 13, 1998 GRACE LAVERA LIPSCOMB JANUARY 7:10 PM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner GARRETT COUNTY MEMORIAL HOSPITAL OAKLAND GARRETT 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) APRIL 27 1 **Funeral** 9. Birthpiace (State or Foreign 1 ☐ M 2 🗓 F Months Deys Hours Min MARYLAND 218-82-1097 83 Yrs. Director 1914 Usual Residence of Decedent death with the Meryland 10a State 10b. County r than "naturel", or Items 23s or 28s-f show The Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits MD GARRETT Director OAKLAND 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4389 Kempton Road 21550 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed w Department of Health end Mental Hygier Important: If Itam 27 is marked other th any Injury or other treumstic event, the NEVER WORKED N/A 17. Father's Neme (First, Middle, Last) Be 18. Mother's Name (First, Middle, Malden Sumeme) **JAMES** RILEY LIPSCOMB VERLINDA ARNOLD 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4389 Kempton Road, Oakland, MD 21550 HELEN LEWIS - SISTER 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State 5 ☐ Other (Specify) 1/16/98 4 Donetion FAIRVIEW CEMETERY OAKLAND, MARYLAND 21. Signetu of I 22. Neme and Address of Fecility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line. Approximete Intervel Between Onset end Deeth Physician Immediate Ceuse (Final diseese or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner The lew requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in deeth) Lest burial-tran Due to (or es e consequence of): Records, P.O. Box 68760. physician attending phys Due to (or es e consequenca of) detached Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? cate has been signed by page 2 should be detact 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Be Completed 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? After this certificate has 1 Yes 2X No 1 ☐ Yes 2 ☐ No Division of Vital spital or Attending Physician: The nours efter death.

nerel Director: After this certificate y filled in by the funeral director, pa 25. Was cese referred to medicel 26. Piece of Deeth (Check only one) 2 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide Hospital 24 hours e 24 hours e to certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

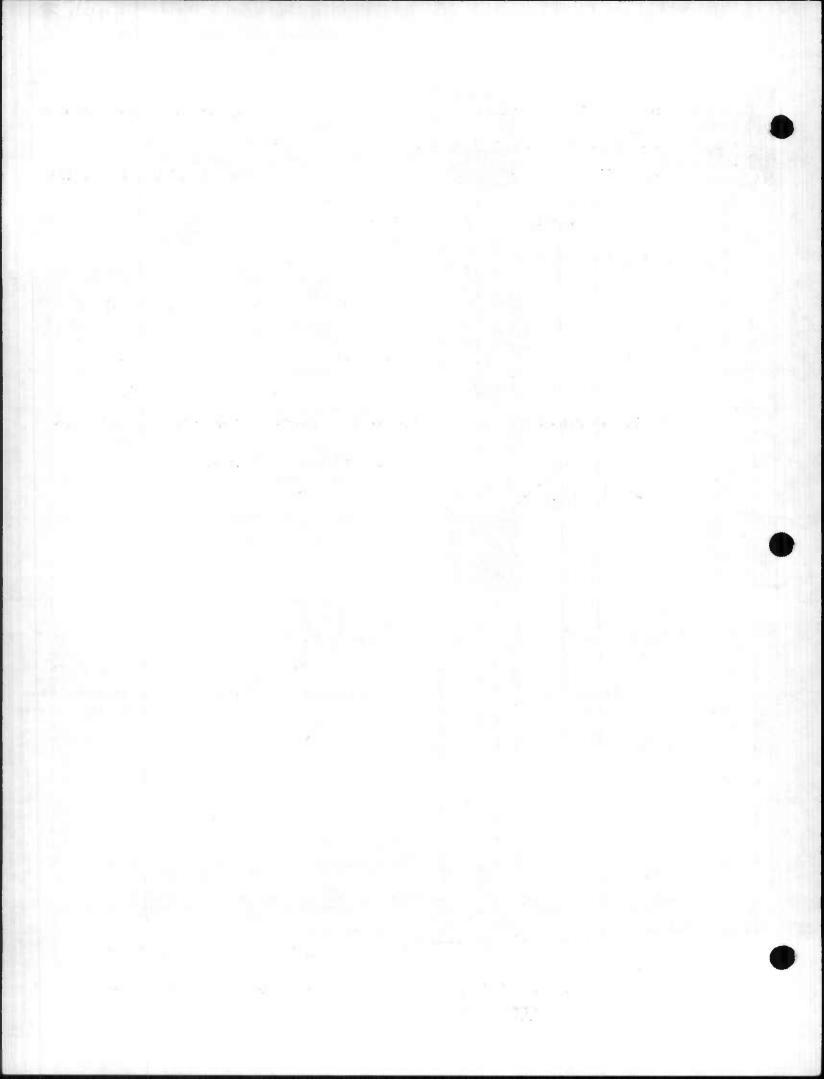
| Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner stated. Medical To the Hosp within 24 hou To the Fune completely fil 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H26154 JANUARY 15, 1998 30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) P. DANIEL MILLER, D.O. 69 WOLF ACRES DRIVE OAKLAND, MD 21550 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

							Certifica	te of	Death	F	eg. No.	UZ	324	
	Ohusia		Decedent's Neme (First, Middle, Last)							th Dey Year 3. Time of		3. Time of Deeth		
	Physic /Medi		Pansy Jane LEWIS							Month January		998	8:00 AM	
ì	Exami		4e. Fecility Neme (If not institution, give street end number)						4b. City, Town, or L		4c. County		0100 1111	
21215-0020			Garrett County Memorial Hospital						Oakland Garrett					
	Funeral		5. Sociel Security Number 6. Sex 7			Age (In yrs. lest birthdey) If Under 1 Yeer If			if Under 24 Hrs.	6. Date of Birth (Month, Dey			ace (State or Foreig	
	Director	Funeral Director	218-32-0770 1 M 2 MF 87 Yrs. Months Deys Hours Min. (Month, Dey, Year) May 3, 1910 West Vi								Virginia			
	fand		10e. Stete 10b. Cour	ty	1	0c. City, Town	or Location			_		10	d. Inside City Limit	
	Mary 4 sh		MD G	0	Oakland				1 ☐ Yes 2 🔯 N					
	15 28 E		10e. Street end Number						Zip Code 10g. Citizen of Whet Country?				rv?	
	filed within 72 hours efter death with the Manyland Hygiene. ther than "natural", or items 23s or 28s-f show ent, the Medical Examiner must be notified at	D	816 Crellin M	ine Deed					01550					
		era	11. Maritai Status					21550 3. Wes Decedent of Hispenic Origin? (S		ecify Yes or No-	USA 14. Race - American Indien,		ın Indien	
		by Fun	1 ☐ Never Merried 2 ☑ M 3 ☐ Widowed 4 ☐ Divorce	erried 1 TY	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Yeer or Detes:		13. Wes Decedent of Hispenic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☑ No Specify:		Plican, etc.) Bleck, 1 Specify:		ck, White, e	etc.		
	hou		15. Deced	ent's Education				el Occu	netion		White 16b. Kind of Business/Industry			
15	in 7	Completed	(Specify only high	nest grede complet	de completed) (Gi life College (1-4or 5+)		Decedant's Usuel Occupetion (Give kind of work dona during most of life. DO NOT use retired)		during most of work	ing	Tob. Islie of Doublesariously		20119	
2	filed with Hygiene. ther ther	mc	Elemantery/Secondary (0-12) Colles			Housewife				Ис	Home		
ivision of Vital Records, P.O. Box 68760,			17. Fether's Neme (First, Middle	e, Last)	110000			- 44 77 7 1		e (First, Middle,	le, Meiden Sumame)			
	0 0 0	To Be	William Bell											
	d 2 should by a not Mental head Mental F is marked traumatic events.	F						s (Stree	t end Number or Rui	rel Route Numbe	City or Town	Trout		
	DENE		Paul W. Lewis						Mine Road				21550	
	- PES		20e. Mathod of Disposition	ndobana		20b. Piece of D			Title Road		20c. Location -			
	Ses H of H		1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other			cemetery,	Cemetery or	other ple		/13/98	0aklan		m, otate	
	permit. Peg Department Important: I any Injury c		21. Signature of Funerel Service	e Liganeee		V	22. Neme e	nd Addre	ess of Fecility			u,		
	88 2 5 8		Stewart Funeral Home 32 S. Second St., Oakland, MD 21550 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haert failure. List only one cause on aech lina. Approximate interval Between											
		Jer.												
	Physician /Medical Examiner		immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Entar Undaritying Cause (Disease or injury their initiated events rasulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of):											
	n certificate be executed anding physician and use as the buriel-trensit	/Medical Examiner												
	eath cel	clan												
	requires that the death car seen signed by the ettendir hauld be deteched for use	Completed by Physician/A												
	2 S D									24e. Wes en eutopsy performed? 24b. Were eutopsy finding eveileble prior to completion of cause of deeth?			ilebie prior to	
	The lew ate hes b page 2 s	5								1□ Y	es 2 kg No	10	Yes 2□ No	
		Be	25. Wes case referred to medic	ai					28. Place of Deal	th (Check only or				
	2 000	To	examinar? 1 ☐ Yes 2 ☑ No	Hospitel: 1								er (Specify))	
	After fune		27. Menner of Death 1 ☑ Neturei 5 ☐ Pence 2 ☐ Accidant inves		ate of injury Month, Dey Y	ear) 28b. Tin	ne of ::	28c. inju Wo 1 □	ryat rk?]Yes 2□No	28d. Describe h	ribe how injury occurred			
	75-6	Certification:	3 ☐ Suicida 6 ☐ Coul 4 ☐ Homicide date	mined 200. C	A Zee, riace of injury - At nome, femil, street, fectory, office						ation (Street end Number or Rural Route Number, r or Town, Stata)			
	To the Hospital of within 24 hours of To the Funeral D completely filled in	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, date end place, and due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of exemination end/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner es stated.										ited. the cause(s)	
	To th	×							License number		29d. Dete signed (Month, Dey, Year)			
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			D26568								1/12/1998			
		4	Dr. Roger Lewis, MD 510 W. State St., Terra Alta, West Virginia 26764											
			Dr. Roger Lewi 31. Dete filed (Month, Dey, Yea		510 W. 2. Registrer's	State	St., T	erra	Alta, We	st Virg	inia 2	6764		
	Sta Registr		JAN	1 2 1998	in la les	Alamente	P. e.							

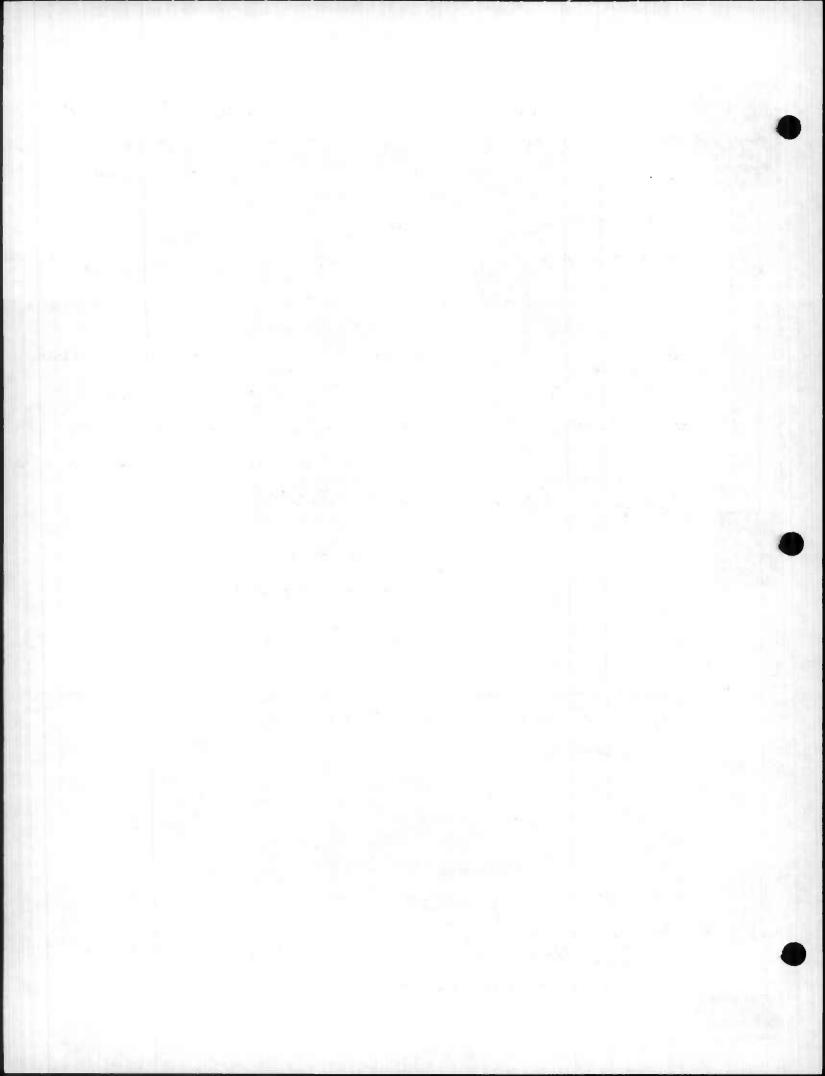


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						ertificate c		ı Merilai riyç	eg. No.	
	Physici /Media		Decedent's Name (First, Middle, Last) Henry Joseph Laqu	ie. Ir.				2. Dete of Dee Month Jan.	Dey Yeer 8 1998	3. Time of Death 6:25 a
	Examir		4e. Fecility Neme (If not institution, give str				4b. City, Town,	or Location of Deeth	4c. County of Death	
			The Memorial I	Hospita	al		Easto	n	Talbot	
	uneral Director		104-18-/86/	4 20 5	ge (In yrs. last birthda 4 Yrs	Months De		Irs. 8. Date of Birth (Month, Dey Jan 7	Year) 9. Birth	plece (State or Foreign ntry)
pue	3		Usual Residence of Decedent 10e. State 10b. County		10c. City, Town or	Location				40d Incide Other Limite
Aaryle	Sho	ō	Maryland Caroline							10d. Inside City Limits Y Yes 2 No
the	288-	Director	10e. Street end Number		Gree	nsboro 10f. Zip Cod	A		0g. Citizen of Whet Cou	
with	3a or		Greensboro Heights,	#2/						,
5-0020 72 hours after death with the Marylend	no mean and wellen rygens. or other Iraumatic event, the Medical Examiner must be notified at	by Funeral	11. Maritel Status 12 1 ■ Never Married 2 ■ Married	. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give	Ever in U,S. 1	216 3. Was Decedent of If Yes, specify C	of Hispenic Origin? uban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	USA 14. Race - Ameri Bleck, White	
Pour	lural'		3 Widowed 4 Divorced	Year or Dates:	16a Do	andontia Haval On				
15 in 72	an" n	Completed	15. Decedent's Educe (Specify only highest grede of	ompleted)	(G	cedent's Usual Oci ive kind of work do b. DO NOT use ret	ne during most of i	working	16b. Kind of Business/Ir	dustry
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befiled investigation	other than	Be C	17. Fether's Name (First, Middle, Last)				18. Mother's N	Neme (First, Middle, i		
arylan	is marked is raumatic ev	TOE	Henry J. Laque, Sr.				Rae	Kate Penn	ington Laqu	P
far, 2 sho	S THE		19a. informent's Neme/Relationship (Type	, Print)	19b. Ma	ailing Address (Stre			, City or Town, State, Zi	
Te, N	n 27		Winifred R. McCoy		Gree	ensboro H	leights,	#34 Green	nsboro, MD	21639
Ore Ses 1	or off		20a. Method of Disposition	noval from Stete	20b. Place of Dis	sposition (Neme of remetory or other p	olace)	Date	20c. Location - City or T	own, State
Fag .	ury (4 □ Donetion 5 □ Other (Specify)			oro Ceme	tery	1/10	Greensboro,	Maryland
Baltimore, Maryland 21215-0020 pemit. Pages 1 and 2 should be filed within 72 hours at Danarim and Marias Havings.	Important: any injury once.		21. Signeture of Furreral Service Licensee	luch		22. Name end Add		ein Funera	1 Home	
			23e. Pert1. Enter the disease, or complice shock, or heart failure. List only one	tions that ceuse cause on eech li	the death. Do not	enter the mode of o	tying, such es cerc	diac or respiretory err	est,	Approximete Intervel Between
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I Records, P.O. Box The law requires that the death cert	ed by the ettendin detached for use	Physician/M	Pert II. Other eignificant conditione contril		A	underlying ceuse	,		es 2 No 3 Pro	bably 4 Unknown
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	icate r. pag							1 🗆 Y	es 20 No 1	☐ Yes 2☐ No
Vicial V	is certificate ha director, page	o Be	25. Was cese referred to medical examiner?	pital:	-5		Other	Deeth (Check only or		
O A	r this	-	1 Yes No	28a. Dete of inju		IERT 3LI DOA	4 □ Nursing njury et Vork?		ence 6 Other (Speci ow injury occurred	<i>fy)</i>
	Afte a fun	itlor	Naturel 5 Pending Investigation	(Month, Da	y Year) Injur		Vork? ☐ Yes 2☐ No			
Division of l or Attending Phys	Director I in by th	Certification:	2 Could not be		ury - At home, ferm, c. (Specify)	street, fectory, offic	ce	28f. Location (S. City or Town	treet end Number or Run n, State)	el Route Number,
Hospita 4 hours	Funeral tely filled	edical C	29a. Certifier (Check only come) Check only 2 Medical Examiner	en: To the best : On the basis o end manuer et	exeminetion end/or	ath occurred et the Investigetion, in m	time, date end ple y opinion, death o	ece, end due to the cocurred et the time, d	euse(s) end menner es a ate end plece, end due	steted. to the ceuse(s)
o the	To the comple	Me	29b. Signature and title of certifier	//	\/	29c. Lice	ense number	2	9d. Date signed (Month,	Dey, Yeer)
F 5	0		> / M	(1:	17		0474	92	1/2/9	8
		Ì	30. Name end eddress of person who comp	pleted ceuse of c	leeth (Item 23e) (Typ	e, Print)	J 1 / L		1/0/1	
			Jeffrey Denton, MD		3 Goldsbo		land 216	536		
	Sta	te	31. Dete filed (Month, Day, Year)	32. Registr	ar's Signeture					

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HENRY

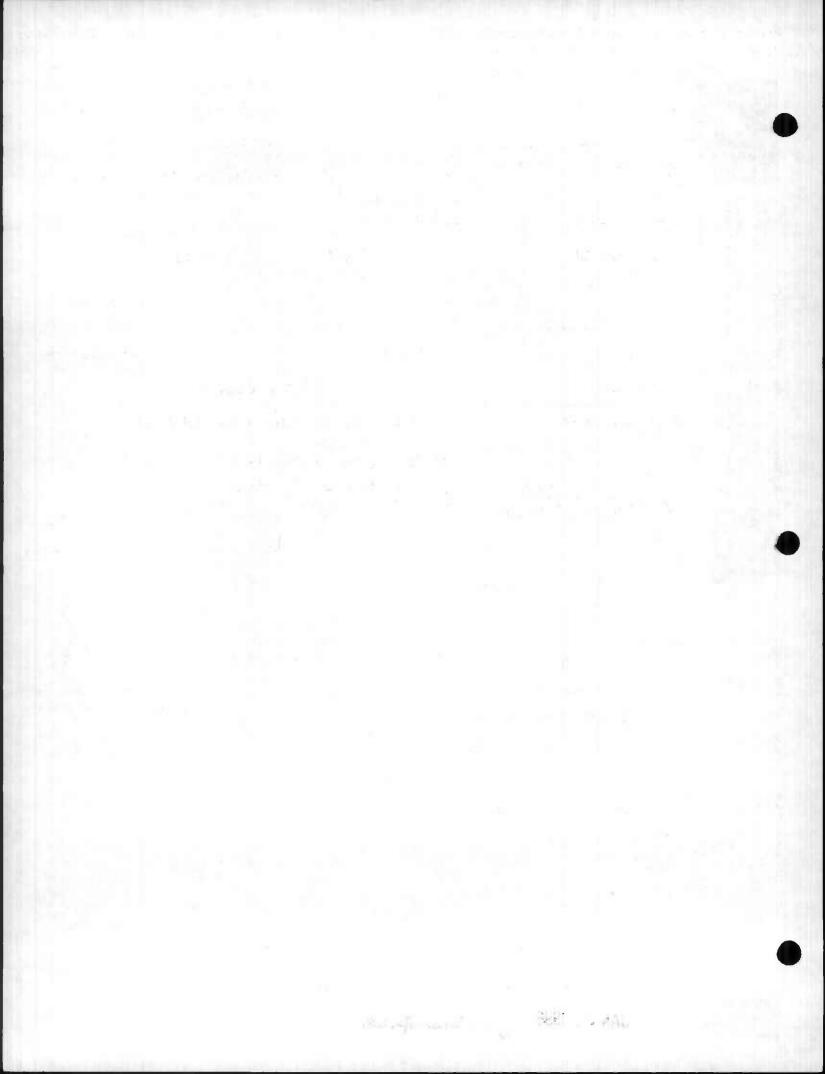


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					Cei	rtificate c	f Death		Reg. No.	U	2020
Physici	an	1. Decedent's Neme (First, Middle, L	est)					2. Date of De Month	Day	Year	3. Time of Death
/Medic		Claude J. Ladd					1	Januar	-	1998	8:00 AM
Examir	ner	4a. Facility Name (If not institution, g		•			4b. City, Town, or				
_		Harford Memorial				If I lados 4 Vo	Havre d			rfora	
Funeral		5. Social Security Number 6. 238 – 34 – 7165	Sex 7. A		last birthday) Yrs.	If Under 1 Ye Months Day		(Month, De	rth ey, Yaar)	9. Birthr	piace (State or Forai
Director		Usual Residence of Decedent		74	113.			Jan. 3	0, 1923	Nort	h Carolin
£ ==		10a. Stete 10b. County		10c. City	y, Town or Lo	cation				1	10d. Inside City Llmi
유	ō	Maryland Cecil		Dix	ing Su	10					1 □ Yes 2 🕱 N
288	ec.	10e. Street and Number		1005	rng sa	10f. Zip Code	a .		10g. Citizen of	Minet Cour	ntn:2
9 8	ā	23 Rolling Dr.								Wilat Coul	tti y r
al', or items 23a or 28a-f show Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Deceden	t Ever in II	S 13 1	2191		nacify Vac or N	USA 14 Ba	ca - Americ	can Indien,
He He	ä	1 Never Married 2 Married	Armed Forces	?	10.1	f Yes, specify C	of Hispanic Origin? (S uban, Mexican, Puer	to Rican, etc.)	Bia	ck, White,	
F, or	by	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:	ww	11	1□Yes 2X	io Spacify:		Specif	y: full	hite
natural', dical Exp	8	15. Decedent's 6			16a Decer	dent's Usuel Oc	cupation		16b. Kind of B		
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tha	EO	Elementery/Secondary (0-12)	College (1-4or	5+)	Pain				Auto M	anuka	icturing
other ent,	Be C	17. Father's Name (First, Middla, Las	t)				18. Mother's Na	me (First, Middla			.ccarreng
ked ked	To B	Jonah Ladd					Lillian	Campbel	P		
mer	-	19a. Informant's Name/Reletionship	(Typa, Print)		19b. Mallir	ng Address (Stra	nat and Number or Ri			Stata Zir	Coda)
27 Is		Texie Ladd/Wife					Dr. Risin				, 5544)
if Heal item 2 other		20a. Method of Disposition		20b. P		sition (Nama of natory or other p		Dete Dete	20c. Location		own. State
2 = 5		1 Burial 2 Cremation 3	Removel from State	9							
ortant: injury		4 ☐ Donation 5 ☐ Other (Space 21. Signature of Funeral Service Lice		wes.			Cemetery !		Colora	, Mar	.yland
any i		21. Signature of Furieral Service Lice		1-	Ŕ	. T. Fo	dress of Facility and Funero	ll Home			
		Tuchard a	- Clos	fre	, 1	11 S. Q	ueen St.	Rising	Sun. MD	2191	1
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each	d he death	n. Do not ent	er the mode of o	lying, such as cerdia	c or respiratory e	rrest,		Approximate Interval Between
ysician			0 7	1	-1	2. 0	1	1			Onset and Death
ledical aminer		Immediate Cause (Final disease or condition	. 0	nd	Sta	ge K	eval	d.sea	· c		2 month
arriller		resulting in death)	. /	Due to (o	r as a conseq	uence, of):	corona		,		zers
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g physician end es the burial-transit	Examiner	Sequentially list conditions,	0.	Due to (or	r as a conseq	uence of):	,		-		110 -
urial		Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury	· olo	M co	e a j	there s	derosi	>		1	1003
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ed fo	Physician/	Part II. Other significant conditions	contributing to death I	but not resu	Ilting in the u	nderlying cause	given in Part I.	23b. Did	tobacco use co	entributa to	o the cause of deat
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pe de	by	- para	toleni	9							
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	piet	Drawe	9 10					perio	ATTIOU?	co	impletion of ceuse death?
4 8	Completed	- (. 1	and la	, 1	15.			10	Yes 2 No		☐ Yes 2☐ No
certificate rector, pag		25. Wes cese referred to medical	LILLE	a	, 200	v	26 Pleas of Da	ath (Check only			3 163 20 140
	To Be	examiner? 1 ☐ Yes 2 No	Hospital:	iest on	ED/Outpetion	2 DOA	Othor:			(0	£.\
rthis aral di		27. Manner of Death	28a. Date of Inj		ER/Outpatien 28b. Time of			lome 5 Resi	dence 6 LIOtr		γ)
Afte	tlor	1 Natural 5 ☐ Pending investigation	(Month, Da	ay Yaar)	Injury	28c. In V	∛ork? □ Yes 2□ No				
y the	Certification:	3 ☐ Suicide 6 ☐ Could not b	OP Place of to	iury - At ho	me farm str	et, factory, offic	200	28f. Location (Straat end Numi	ber or Rura	al Routa Number,
Dir b	erti	4 ☐ Homicide determined	building, e	c. (Specify)	oot, ractory, ome		City or To	wn, Stete)		o riodia ridinosi,
fillec		29a. Certifier Cartifying P	nysician: To the best	of my know	uladaa daath	occurred at the	time, data and place	and due to the	causo(s) and m	22222	tatad
Fun	edicai	(Check only one)	miner: On the basis of end manner si	of examinat	ion end/or Inv	estigation, in m	y opinion, deeth occu	rred at the time,	date and place,	and due to	the ceuse(s)
To the Funeral Director: After this completely filled in by the funeral	M	29b. Signature and title of certifier	A. A.			29c. Lice	inse number		29d. Date signe	d (Month	Day, Yaar)
		61.1	Van	\	M.A	7	1827	. /	1/12	98	y
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1		30. Name end address of person who							,		
			S. Union			e de Gri	ace, MD 21	078			
Sta	to	31. Date filed (Month, Day, Yaer)	32. Regist	rar's Signal	ture						

Registrar

JAN 2 0 1998 Julia Savidson Bondson

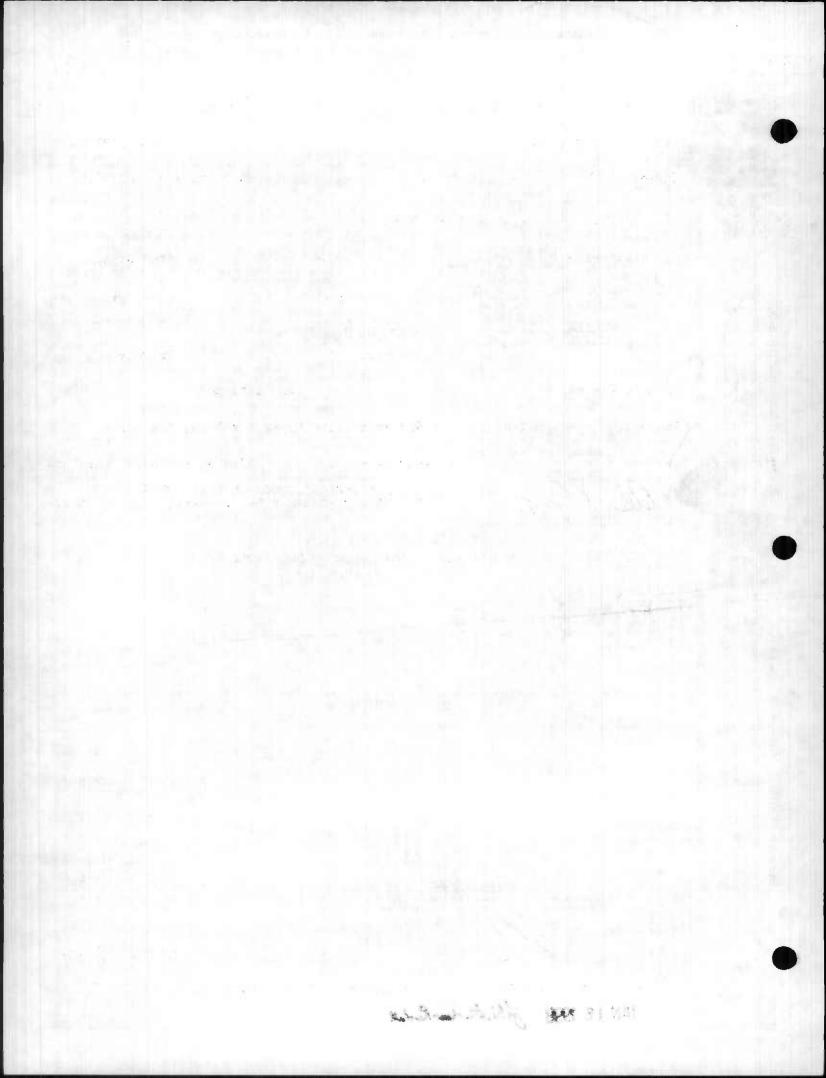


98-0110-033 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene ANTONIO JOEL Certificate of Death LITTLETON Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey **Physician** ANTONIO JOEL LITTLETON 22:40 PM JANUARY 07,1998 /Medical 4e Fecility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** PRINCE GEORGES 8611 WESTPHALIA ROAD FORESTVILLE If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1□XM 2□ F Months Deys Yrs. Director 217-90-2090 30 May 14, 1967 Maryland Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 3/1 Directo Upper Marlboro Maryland Prince Georges 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or items 23s or 828 Avis Drive 20774 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes, 2 No If Yes, Give Year or Dates: 14. Rece - American indien, 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 72 hours efter 1 X Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced 2 should be filed within 72 hou end Mentel Hygiene. Is marked other then "natura surmatic event, tra Medical E Completed 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Private 10 Ith and Mental Hygiv 27 is marked other traumatic event, ii 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Francis Pinkney Ann Littleton 10 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum page. 19e. Informent's Name/Reletionship (Type, Print) Ann Smith Mother 828 Avis Drive Upper Marlboro, Md. 20774 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Harmony Memorial Park 1/14/98 Landover, Maryland 22. Name end Address of Fecility ALEXANDER S. POPE FUNERAL HOMES M859 5538 Marlboro Pike, Forestville, Md. alons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximete Intervel Between Onset and Death 23a. Part1. Enter the disease, of complications, or heart failure. List only one **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Multiple Gunsh Due to (or es e consequence of): Gunshot Wounds Examiner Examiner ettending physician end for use as the buriel-trensit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medicai Due to (or as e consequence of): signed by the e 23b. Dfd lobecco use contribute to the cause of deeth? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? should should 24a. Wes en eutopsy Completed is certificate has director, pege 2 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCENE 1 Yes 2 No 70 this funeral 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: After 22 30M 1 Neturel 5 Pending Subject Shot 1 Yes 2 No investigation 1-7-95 deeth. Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours efter the Funeral Dire mpletely filled in b westphalia Hospital 29a. Certifier 1 Certifying Phyeicfen: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted. Medical (Check only one) Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and medical end medical end medical end medical end medical end medical end medical end of the cause To the 1 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dev. Year) OCME JANUARY 08, 1998 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Powler JUNIA

State Registrar 31. Date filed (Month, Day, Yeer) JAN 12 193

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 9:58 AM HOURR Michael Francis Littleford /Medical 4e. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Prince George's Lanham If Undar 1 Year if Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours Min. 1⊠M 2□F Yrs. 57 Wisconsin Director 215-38-4343 1940 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 X Yas 2 □ No Director Maryland Prince George's College Park 10e Street and Number 10f. Zin Coda 10g. Citizen of What Country? 4806 Indian Lane 20740 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, atc.) Rece - Amaricen Indian, Bleck, White, atc. 11. Maritai Status 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Naver Married 2 ☐ Married 1 Yes 2 No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) Entomologist Insect Research 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Α. Littleford Genevieve Everett 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genevieve Littleford - Mother 4806 Indian Lane, College Park, Maryland 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 X Buriai 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate Of Heaven Cemetery 1/15/98 Silver Spring, Maryland 21. Signature of Funeral Sarvice Licenses 22. Name and Address of Fecility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 erea 23a. Part1. Enter the disaese, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) e. ACUTE MYOCAR 101AL

Due to (or as e consequence of): Examiner PERIPHERAL F
Due to (or es a consequence of): ARTERIAL Sequantially list conditions, if eny, leading to immadiate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting in death) Lest FSSENTIAL Physician/Medical Part ii. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings availabla prior to completion of ceuse of deeth? Completed 24a. Was en eutopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was cese referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Menner of Death 28d. Describe how injury occurred 28e. Dete of injury (Month, Day Year) 28h Time of 28c. Injury et Work? 5 Pending Investigation 1 Neturai 1 □ Yas 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical 1/2 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as steted. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29b. Signeture and titla of certifier 29c. Licensa number 29d. Date signad (Month, Day, Year) Mas 30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print) 4917, EDGE WOOD RD. COLLEGE DIC. MD 20740. AZHER HUSSAIN. MD 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State

Registrar **DHMH 16 Rev 6/95**

JAN 14.19

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na 23a or 28a-f sho must be notified at

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marked other

mportant: If Item 27 is any Injury or other traus of Health

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Hospital

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Box 68760,

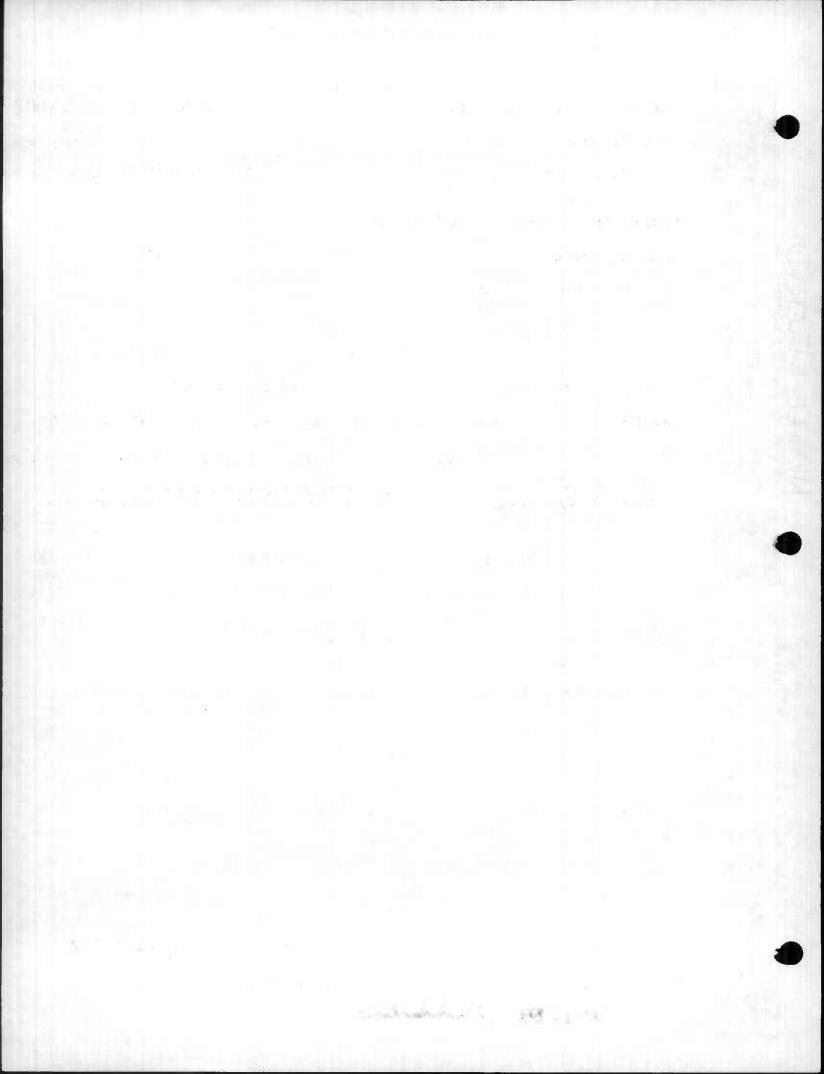
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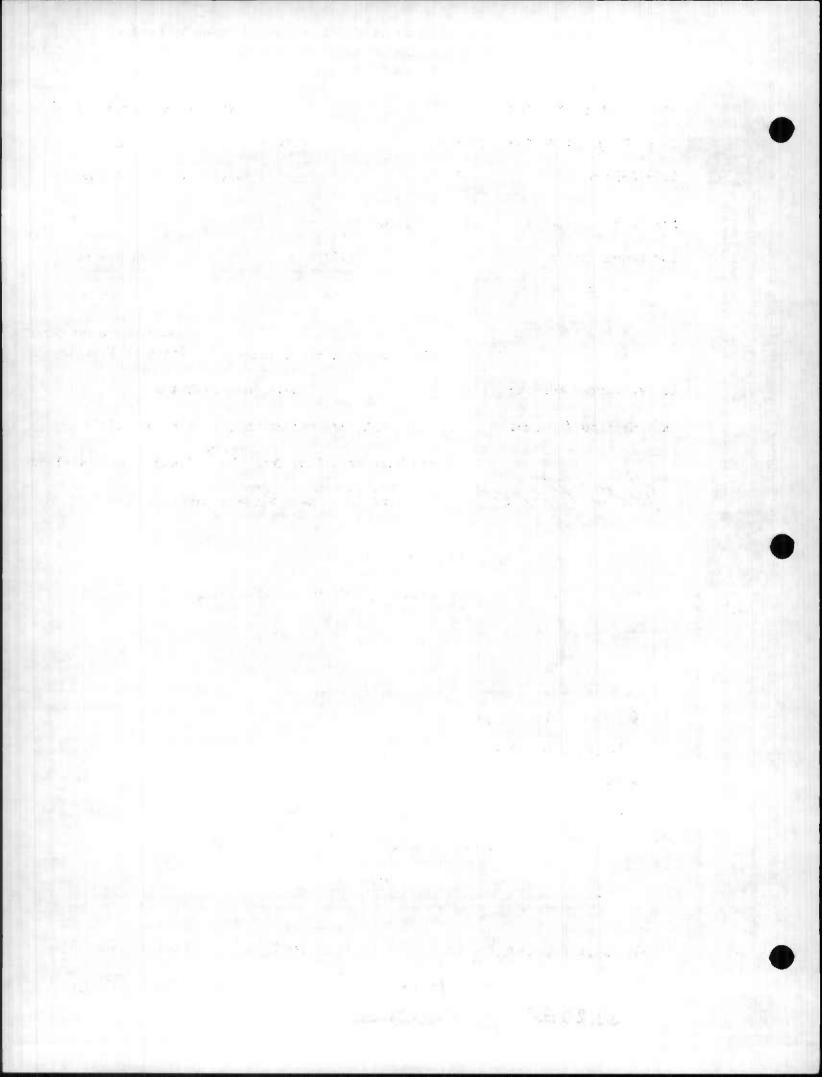
1 and 2 should be Health and Mental

the Medical



1. Decedent's Name (First, Managery) John Harvey 4a Facility Name (If not institute Union Hospita) 5. Social Sacurity Number 215-10-5986	Meel						2. Date of De	ath		
4a Facility Name (If not institute Union Hospita 5. Social Sacurity Number 215–10–5986		kins					Month	Day	Yaar	3. Time of Death
Union Hospita 5. Social Sacurity Number 215-10-5986	tion, give s						Januar			13:00
5. Social Sacurity Number 215-10-5986		street and nu	m <i>ber</i>)			4b. City, Town, or L	ocation of Deat	h 4c. County	of Death	
215-10-5986	1 of	Cecil	County			Elkton			Cecil	
	6. Sax	M 2 F	7. Aga (In yrs.		If Undar 1 Yaar Months Days		8. Date of Bi (Month, Da	rth ay, Year)	9. Birthplac	ca (State or Foreign
		100 201	83	Yrs.			April	1, 1914	Mary	land
Usual Residence of Decedent 10e. Stete 10b. Cou	nty		10c. C	ity, Town or Lo	cation				100	I. Inside City Limits
										1⊠ Yes 2 No
Maryland 10e. Street and Number	Ceci	LI		E1kto	10f. Zip Code			10g. Citizen of V	What Country	12
100 Laurel Dr		12 Was Dece	edent Evar in U	IS 13 V	2192		necify Yes or No	United	e - Amaricer	
1 Never Married 2 Nover Marrie	larried	Armed Fo 1 Tes If Yes, Giv Yaar or D	orces? 2⊠ No ve		Yes, specify Cul	Hispanic Origin? (Span, Mexicen, Puerto Specify:	o Rican, atc.)	Blac	ck, White, etc. Whit	0.
	lent's Educ			16a. Deced	ent's Usual Occu	upation		16b. Kind of Bu	siness/Indu	stry
(Specify only hig Elementary/Secondary (0-1		College (1-4or 5+)	life. L	Kind of work done OO NOT use retin	during most of world	KING	U.S. Go	vernme	ent Naval
12	-/	Conogo (401 017	Profes	ssional	firefight	er	Trainin	ng Fac	ility
17. Father's Nama (First, Mide	lle, Last)					18. Mother's Nen	ne (First, Middle	, Maiden Surnam	10)	
Andrew Warrer	Meel	kins				Sadie A	nnamae	Evans		
19a. Informant's Name/Relati	onship (Ty)	pe, Print)		19b. Mailin	g Address (Stree	et and Number or Ru	ral Route Numb	er, City or Town,	State, Zip C	ode)
Jane Meekins	/ Dat	ughter		507 Ho	ollingsw	orth Aven	ue, Elk	ton, MD	2192	1
20a. Method of Disposition				Place of Dispo-	sition (Name of natory or other pl		Data Jan. 23	20c. Location -	City or Town	n, State
1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		emoval from	Stata			dist Cem.	1998	North E	ast. N	Maryland
21. Signature of Funeral Sery	ce Ligaçõe	98		22	. Name and Addr	ress of Facility				
MILKL	//-	. 0	1			neral Hom			MD	21901
23a. Part1. Enter tha diseasa shock, or heart failure.	or compli	cations that o	ausad the daa			Main Str			P	Approximate ntervel Between
Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	{) :	Due to (or as a consequence or as a consequence	uence of):	tery D	ye se			
Part II. Other significant cond	itiona con	tributing to de	eath but not re	sulting in the ur	nderlying ceuse g	iven in Part I.				ha cause of death'
COPD	40) yea	(S				1	Yes 2□ No	3 Proba	bly 4 dnknow
							24a. Wa:	s an autopsy		autopsy findings
Abdon	inal	Au	tic a	neury	~		perf	ormed?	com	able prior to pletion of causa eath?
CVAS								• • • • • • • • • • • • • • • • • • • •		
			_					Yes 2□No	10	Yes 2□ No
25. Was cese refarred to med examiner? 1 ☐ Yes ② No	-	lospitel:		1 com (- (:		26. Place of Dea	-		(0	
27. Manner of Death Naturel 5 ☐ Per	ding estigation	28a. Date (Mon		28b. Time of Injury	28c. Inj	4 Zwursing m		idence 6 Oth how injury occur		
	old not be ermined	28e. Place buildi	of Injury - At h	nome, farm, straify)	eet, factory, office	Ð	28f. Location City or To	(Street and Numb own, State)	per or Rural i	Route Number,
29a. Certifier (Check only one) 12 Carti	ying Phys al Examir	ner: On the b	best of my kn asis of examin ner stated.	owledge, death ation and/or inv	occurred et the restigetion, in my	time, dete end plece opinion, death occu	, and due to the irred at the time	cause(s) and ma , date and place,	anner as sta and due to t	ted. he cause(s)
29b. Signatura and titla of car	ifiar			24 2 7	29c. Licer	nse number		29d. Date signe		
Alana	. Ma	ine !	Ma	200	0.5	0195		Januar	y 20,	1998
000	on who co	mpleted ceus	se ordeath (Ite	m 23a) (Type,		-, ()	(7)	Januar on Marie	0	
30. Name and eddress of pers	mical	Lua	7 725	inflin	Um,	21911	Shan	on Maria	Par	INV

DHMH 16 Rev 6/95



L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physics	. OIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial. Druns after death with the State Dent of Health and Mental Horline prior to burial, cremation or removal.	item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
N: The	State	item
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IMPORTANT:

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31. DATE FILED (Month, Day, Year)

FUNERAL WITHIN 72 H HOSPITAL

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Pages 1, 2, 3 should

permit.

98 023**30** FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Alice Maeder Jan 0400 AM 10 4. SOCIAL SECURITY NUMBER 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 578-46-9657 87 YRS. DAYE HOURS 1 M 2 X F Aug. 23, 1910 Boston, Mass. 9a. FACILITY NAME (If not Institution, give street and number) 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Hyattsville Sacred Heart Home Prince George's RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 K YES 2 NO Washington, D.C. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1009 East Capitol Street, S.E. 20003 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify Specify: BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EOUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elamentary/Secondary (0-12) College (1-4 or 5 +) 12 Governess Domestic 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Byrne Patrick J. McKenna BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Harold Maeder, Husband 1009 E. Capitol St., S.E., Washington, D.C. 20003 20a. METNOD OF DISPOSITION
1 💢 Burial 2 🗆 Cremation 3 🗆 Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE Fort Lincoln Cemetery Donation 5 - Other (Specify) 1/14/98 Brentwood, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Fort Lincoln Funeral Home vez 3401 Bladensburg Rd., Brentwood, MD 20722 23. PART I. Enter the diseases, or complications that caused the death Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate ehock, or haert feilure. List only one cause on each line interval Between Right Lower Lobe Preumonia.

OUE TO (OR AS A CONSEQUENCE OF): Onset and Death IMMEDIATE CAUSE (Final disease or condition 5 6945 resulting in death) CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO MEDICAL Congestive Heart Failure Mily Value Regugitation, Lew- + Block, Old Right Kephrectony, Hypothyroidism COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO INCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? HOSPITAL: OTHER:
4 Mursing Name 8 Residence 8 Other (Specify) 1 | Inpetient 2 | ER/Outpetient 3 | DOA 27. MANNER OF DEATN 28c. INJURY AT WORK? 28a. DATE OF INJURY 28b. TIME OF 28d. DESCRIBE NOW INJURY OCCURED 1 Netural 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, term, street, factory, offica building, etc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Nomicide determined 29a. CERTIFIER

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(a) and manner as stated. 29c. LICENSE NUMBER BE

MA Covering Physician D31001 >
WNO COMPLETED CAUSE OF DENTH (ITEM 27) (Typo, Print) 7500 Greenvay Cata.

Greenbelt, MD.

kewitz, M.D

32. REGISTRAR'S SIGNATURE

A Sela Divolen Replat

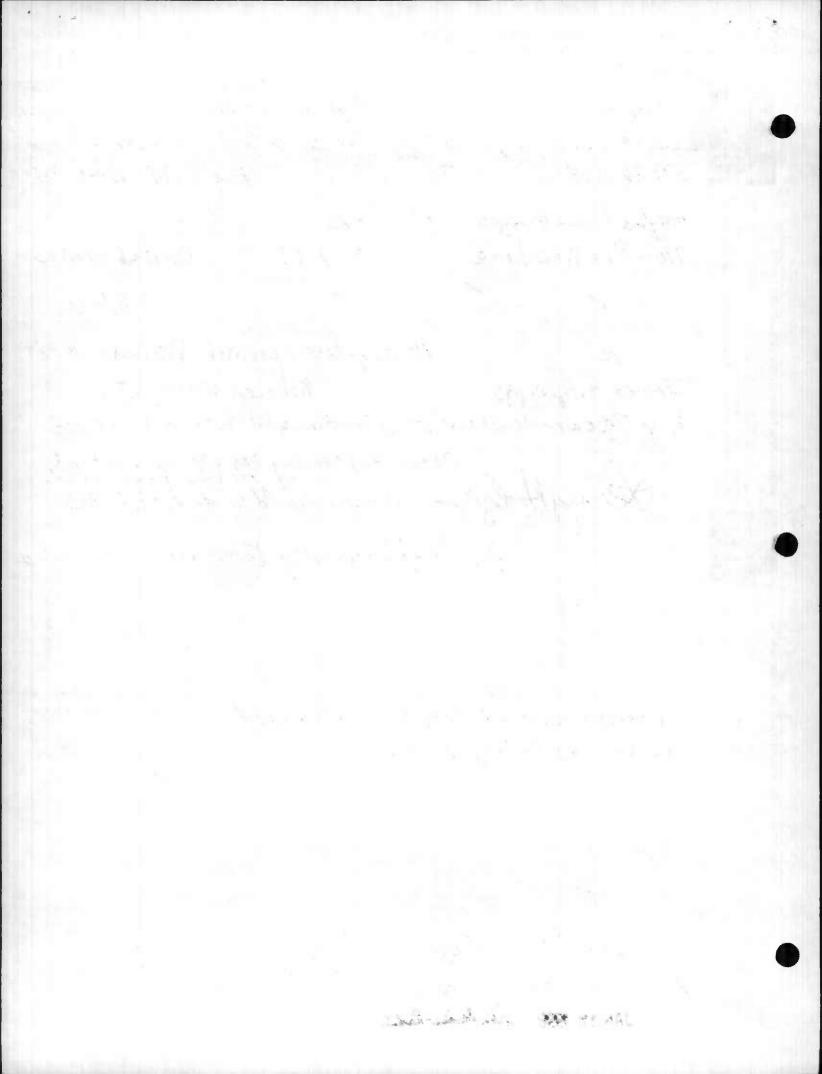
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Manager and the second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death
	Obveio		1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death
	Physici /Medi	_	Cheida - Mathews Jan. 8, 1998 3:15 pm
	Examir	ner	4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Ĭ.			Southern MARY AND HOSPITAL CLINTON STUNCE THOUSES
п	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 9. Birthplaca (State or Foreign Month, Day, Yagr) Country) 9. Birthplaca (State or Foreign Month, Day, Yagr) Country)
	Director		Usual Rasidance of Decedent Usual Rasidance of Decedent
	show		10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits
	ith with the Maryla 23a or 28a-f shout be notified at	to	MARIAN Rince Georges Clinton
	or 28	ire	10e. Streat and Number 10f. Zip Coda 10g. Citizan of What Country?
	23a	ie.	19/06 Pine View LANE 20735 United STATES
	er dea	Funeral Director	11. Marital Status 12. Was Decedant Evar In U.S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc.
20	s efter des	by F	1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: Specify:
21215-0020	E		5 Wildowed 4 tar Divorced Year or Datas:
15	in 72 ho	ojet	15. Decedant's Education (Specify only highest greds completed) 16e. Decedant's Usuel Occupation (Give kind of work done during most of working III. DO NOT use Patrice III. DO NOT use Patrice III. DO NOT use Patrice
212	filed within Hygiene. ther than out, the M	E O	Elamantary/Secondary (0-12) Collaga (1-40r5+) PRITING (RESS OPERATOR PRIVINGE GOVT
	0 = 0	Be Completed	17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Surnama)
Maryland		ToE	JAMES A. Speigas Reporce Washington
lan	d 2 should th end Mer 7 is marks traumatic		19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
	f Health frem 27 i		thy BROWN-DAUGHTEN 1/323 BRANDYWING Kd Clinton md, 20735
Baltimore,	of H		20a. Mat/locd of Disposition 20b. Place of Disposition (Nama of Communication of City or Town, State Communication of Communication of City or Town, State Communication of City or Ci
Ë	0 6 4 >		4 Donation & Other (Specify) Coppetition Compatibility Cometary Dan 48 Sultano mo
Sal	permit. Pe Depertmen Important: any Injury once.		21. Signature of Juneral Service Licenses 22. Name and Addrass of Facility Hodges - Edwards/First
)	00540		May Hotels 39105:18-14/11 Rd, Sucol med, Mo, 20735
			23a. Part1. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between
	Physician /Medical		Onset and Deeth
	Examiner		Immediata Causa (Final disages or condition resulting in death) a. Acule full monary Edenva. One day
		-e	Due to (or as a consequence of):
	d d ansit	Examiner	Sequantially list conditions. Dua to (or as a consequence of):
ó	ste be executed hysicien end the buriel-transit	EX	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents Due to (or as a consequence of):
09289	ficete be exe physicien e ss the buriel-	edicai	Causa (Diseasa or injury c. ———————————————————————————————————
	ifig Se		additing in doorly base
Box	death certif e ettending ed for use e	and	d.
	0 0 0	Sic	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?
P.0	= >0	Completed by Physician/M	Pholymone - Condensor Carlos Accide of 10 Yes 25 No 30 Probably 40 Unknown
Division of Vital Records,	w requires thet sbeen signed t should be det	by	1 - Comment of the contract of
Ö		etec	Coronary Antry Bycese. 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of causa of death?
360	W W CV	d H	of dauth?
a	icete h		1 □ Yas 2 No 1 □ Yas 2 □ No
\ <u>\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\</u>	Physician: The law this certificete hes t rel director, page 2 s	9 Be	25. Was case referred to medical axaminar? 1 Yes 27 No
of		5. To	1 Umpatiant 2 ER/Outpatient 3 DOA Versing Homa 5 Rasidance 6 Othar (Specify)
O	th. : Afte	tior	27. Mannar of Death 1 Death 28a. Dete of Injury 28b. Time o
Visi	Atter r dee octor by th	HC2	3 Suicida 6 Could not be determined 28a. Placa of Injury - At homa, farm, street, fectory, office 28f. Location (Streat and Number or Rural Route Number,
Ö	s efte	Certification:	4 ☐ Homicida building, atc. (Spacify) City or Town, Stata)
	hour hour uners		29a. Cartifier (Check only Addical Framinar: On the basis of examination and/or investigation, in my onlying death occurred at the time, data and place, and due to the causa(s) and mannar as stated.
	To the Hospital or Attending Phy within 24 hours eliet cleah. To the Funeral Director: Affer thi completely filled in by the funeral	edicai	(Check only one) 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.
	To t To t	Σ	29b. Signatura and titla of certifiar , 29c. Licansa number 29d. Data signad (Month, Day, Yaer)
	(1)		Sam y Walle 134214 1-9-98
	4)		30. Nama and address of person who completed causa of death (Item 23e) (Type, Print) 7700 01d Bamuch Ave, Fre B-D
	()		ESSAM Y. 12/1AWI, MD Clinton, Mil 30735
	Sta	te ar	31. Data filed (Month, Øay, Yaer) 32. Begistrár's Signatura



State of Maryland / Department of Health and Mental Hygiene 8 0 2 3 3 2

							Cer	tificate o	of Death		Reg. No.	0	
			1. Decedent's Ner	ne (First, Middle, Le	ıst)					2. Dete of D	eath		3. Time of Death
	Physic		Sarah H	oward Mur	rav					Month	Dey 8,1998	Yeer	3:40 AM
3	/Medi Exami			(If not Institution, given		ber)			4b. City, Town, o			ounty of Deetl	
1	Exami	iici					ina C	ontor	Cilvor	Spring			
	Funeval		5. Sociei Security	se Rehabi		7. Age (In yrs. lest						ntgome	
	Funeral Director		577-24- Usuel Residence	0208	1□м ЖЙ F	95	Yrs.	Months De	ys Hours Min		27, 19	02 Was	hpiece (Stete or Foreign untry) Shington, DC
	yland		10e. Stete	10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
	e Mar	ctor	Maryland	Montgom	ery	Silv	er S	pring					1 √ Yes 2 □ No
	be filed within 72 hours effer death with the Maryland ntel Hygiene. Id other than "natural", or flems 23a or 28a-f show event, the Medical Exerteet must be notified at	al Director	10e. Street and Nu 2015 E	ast West	Highway			10f. Zlp Code 209				ed Sta	
	9 E T	Funeral	11. Maritei Stetus		12. Wes Deced	dent Ever in U,S.	13. V	Ves Decedent o	of Hispenic Origin? (Juben, Mexicen, Pue	Specify Yes or N	10- 14.	. Race - Amer	
020	al', or its	by	1 Never Mer 32 Widowed	ried 2 Married 4 Divorced	1 Tes If Yes, Give Yeer or De	No No		☐ Yes ¾™ N		nto riloan, etc.)		Bieck, White pecify:	Black
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ore	of He		20e. Method of Dis			20b. Place	of Dispos	sition (Neme of netory or other p	Street,	Jan.	20c. Loca	tion - City or	Town, Stete
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Ä	Depar Depar Impor any ir		John	W. Lat	ney, J	7.		8831 Geo	orgia Ave	, NW Was	shingto	on, DC	20011
ı			234 Part1. Enter shock, or he	the diseese, or coment failure. List only	pilcations that ca	used the death. [o not ente	er the mode of o	dying, such es cerdi	ec or respiretory	errest,		Approximete Interval Between
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o	0 0 %	ysi	Pert ii. Other signi	ficent conditions	ontributing to dea	th but not resultin	g in the un	derlying cause	given in Pert i.	23b. Die	d tobacco us	e contribute	to the causa of death?
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ec	8 8 6	npi										0	of deeth?
	The I	Con								1 🗆	Yes 2🖾	No 1	1 ☐ Yes 2 ☐ No
Vital	Iclan: The certificate rector, peg	Be	25. Wes case refe examiner?	rred to medical					26. Place of De	eth (Check only	one)		
>	Physician: this certific ral director,	0	1 ☐ Yes 🍇	₹No	Hospital: 1 ☐ in	patient 2 ER/	Outpetien	3 DOA	Other: 4 Nursing	Home 5 ☐ Re	sidence 6 [Other (Spec	cify)
of		n: T	27. Menner of Dee		28e. Dete of	injury 28	b. Time of	28c. in	njury et Vork?	28d. Describe			
Division	Attending For death. actor: After by the funer	Certification:	1 Accident	5 Pending investigation		, Dey Year)	injury		Yes 2 No				
18	al or Attendin sefter death. I Director: Af d in by the fu	fice	3 Suicide	6 Could not b	200. Placa C	of Injury - At home	, ferm, stre	et, fectory, offic	ca	28f. Location	(Street end I	Vumber or Ru	irei Route Number,
á	Olra din l	ert	4 Homicide		building	g, etc. (Specify)				City or T	own, State)		
	Hospita 24 hours Funera tely fille	edicai C	29a. Certifier (Check only one)	1⊠ Certifying Ph 2☐ Medical Exam	niner: On the bas	ils of exeminetion	dge, death end/or inv	occurred et the estigetion, in m	time, dete end pled y opinion, deeth occ	ce, end due to the curred et the time	e cause(s) en e, date end pi	id menner es ece, end due	steted. to the ceuse(s)
	To the within 2 To the comple	Me	29b. Signature and	title of certifier	end manne	or stateo.		29c Lice	ense number		29d Date s	signed (Month	h Dev Yearl
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	161		30. Neme end edd	ess of person who									
1	0/		Marc Sh 31. Dete filed (Mor	enard	2021	K Stree	t, NW	Washin	ngton, DC	20006			
	Sta	ite			- 4 1	gistrar's Signature		4					
	Registr	ar	JI	an 12 19 5	N . YAY	adhudbar	10th	4					

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 07:30 PM 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month J ANUARY ALLEN MARTIN 10 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth PRINCE GEORGES HOSPITAL CENTER PRINCE GEORGES CHEVERLY 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Dey, 6. Sex 14 M 2 □ F 9. Birthplece (State or Foreign Deys 32 Yrs. WASHINGTON, D.C. JUNE 23, 1965 10b County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MARYLAND PRINCE GEORGE'S HILLCREST HEIGHTS 10f. Zip Code 10g. Citizen of Whet Country? 20746 UNITED STATES 3370 CURTIS DR. #303 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Bieck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ₩ Never Married 2 Merried 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LANDSCAPER PRIVATE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) LaVERNE THOMAS GEORGE S. MARTIN 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) #303 19e. Informent's Name/Relationship (Type, Print) 3370 CURTIS DR. HILLCREST HEIGHTS, MD. 20746 LaVerne Blocker/MOTHER 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 1X Buriei 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 1/20/98 LANDOVER, MD. HARMONY MEMORIAL PARK 21. Signeture of Funerai Service Licensee ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE/FORESTVILLE, MARYLAND 20747 71085 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death · ACQUIRED IMMUNE DEFICIENCY SYNDROME Due to (or es e consequenca of): Due to (or es e consequence of) Due to (or es e consequença of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed?

Physician /Medical Examiner

physician s the buriel

signed by t

hes certificate

funeral

filled in by

Be

2

Certification:

Medical

Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certific

24 hours e

To the Vilthin 2

Box 68760.

P.0.

Records,

Division of Vital

Immediete Ceuse (Final diseese or condition resulting in deeth) Examiner **buriel-trensit** pue

Physician

/Medical

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f ahow traumstic event, tra Modical Examinar must be notified at

permit. Peges 1 end 2 should be flied within 72 hours effer or Department of Heelth end Mental Hyglene. Important: If Nem 27 is merked other than "natural", or iten any Injury or other traumatic event

Baltimore, Maryland 21215-0020

the Meryland

death

5. Sociel Security Number

578-06-2344

10e. Street end Number

20a. Method of Disposition

10a Stete

Director

Funeral

þ

Completed

Be Lo Usuel Residence of Decedent

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieled events resulting In death) Lest Physician/Medical by Completed

25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

Hospitei: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28e. Dete of Injury (Month, Dey Year) 5 Pending investigation 6 Could not be determined

28c. Injury et Work? 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

DME

28d. Describe how Injury occurred

1 ☐ Yes

1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end members. On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner and the control of the cause(s) end menner and the control of the cause(s).

, CHEVERLY, MARYLAND 20785

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

(Check only one)

Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29c. License number

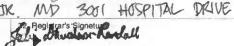
29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

MARIO F. GOLLE

31. Dete filed (Month, Dey, Year)



Registrar

Account the safety by goods profits

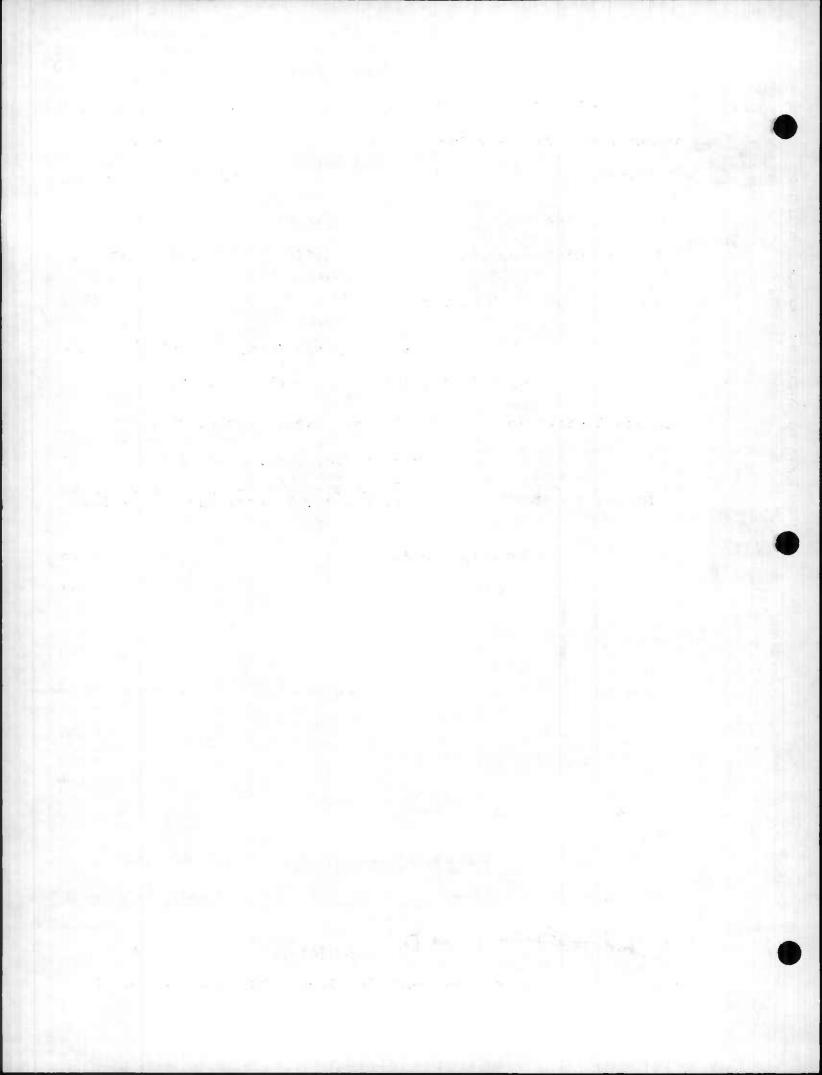
State of Maryland / Department of Health and Mental Hygiene 9 8 0 2 3 3 4

					Certific	cate of	Death		Re	g. No.	U	2004
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Physicia /Medic		Frederick Henry	Mayland						January	Dey 10, 19	Yeer 998	11:55 ar
Examin		4e. Fecility Name (If not institution, given	re street end number)				4b. City, To		ation of Deeth	4c. County		, , , , , , , , , , , , , , , , , , , ,
		Holy Cross Hosp	ital				Silv	er Sp	ring	Monts	gomer	y
Funeral Director			Sex 7. Age (III	96		Inder 1 Year nths Deys	If Under	24 Hrs. 8	B. Date of Birth (Month, Day, une 17,	Year) 1901	9. Birthp Court	iece (Stete or Forei
		Usual Residence of Decedent						Υ.	2,,	1701	Douc	п вакоса
how H		10a. State 10b. County	10	c. City, Town	or Location	n					1	0d. Inside City Limi
the state of	cto	Maryland Prince	George's	Berwyn	n Hei	ghts						1 ₹ Yes 2 N
or 28	Director	10e. Street end Number			10	of. Zip Code			10	g. Citizen of V	Vhet Cour	itry?
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jiene. The Medical Examiner mant be notified at The Medical Examiner mant be notified at	y Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give	r in U,S.		Decedent of specify Cub			ify Yes or No- ican, etc.)		k, White,	
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"natural", o	Completed by	15. Decedent's E (Specify only highest gro	ade completed)	16e. l	Give kind	Usuel Occu of work done OT use retire	petion during mos	t of working	, 1	6b. Kind of Bu	isiness/Ind	dustry
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or or		1 ☐ Burlel 2 ☐ Cremetion 3 ☐	Removel from Stete	cemetery	, cremetor	y or other ple				Oc. Location -		
Department of Health er Important: If Item 27 le any Injury or other trau		4 □ Donation 5 □ Other (Special	iy)	Metrop	olita	n Crei	natory	1/	13/98	Alexano	dria,	Virgini
ny in		21. Signature of Funeral Service Liqu	nsee		22. Nan	ne end Addr	ess of Fecilit	ty				
01 9 8		Mancy U. Th	any son		Franc	Cis Ga	sch's	Sons	Funeral Hyatt	L Home,	P.A	20781
	al Examiner	disease or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse, Disease or injury	b	e to (or es e co	onsequenc							
in e	an/Medical	thet initiated events resulting in deeth) Lest	d	to (or es e co	onsequence	of):						
ed by the detached	by Physician	Pert II. Other significant conditions of	ontributing to death but no	ot resulting in	the underly	ring cause gi	ven in Pert I	•	23b. Did tob	~		the cause of dea
	Completed b								24a. Wes en		eve	ere eutopsy finding eilable prior to mpletion of ceuse deeth?
page page	OO								1□ Yes	2 No	10	Yes 2□ No
£ 5	Be	25. Wes cese referred to medicel examiner?					28. Plece	of Death (Check only one			
0 O	2	examiner? 1 ☐ Yes No	Hospital: 1 Synpatient	2 ER/Out	patient 3[DOA Ot	her: 4 Nu	irsing Home	e 5 ☐ Residen	nce 8 Othe	er (Specif	y)
		27. Menner of Deeth Naturel 5 Pending Accident Investigation	28e. Date of Injury (Month, Dey Ye	28b. Ti	ime of jury	28c. Inju Wo		28	d. Describe how			
arter deetin. Director: A d in by the fu	Certification:	3 Sulcide 6 Could not b		At home, feri pecify)					f. Location (Stre City or Town,		er or Rura	l Route Number,
Funer Funer stely fill	edical C	29a. Certifier (Check only one)	ysician: To the best of my niner: On the besis of exa end menner steted.	y knowledge, minetion end	deeth occu /or investig	irred et the ti ation, in my	me, date en opinion, dee	d place, en th occurred	d due to the cet let the time, dat	use(s) end me te end place, e	nner es si and due to	teted. the ceuse(s)
To the comple	W	29b. Signature end title of certifier	On			29c. Licen:		_		d. Dete signed		Dey, Year)
2)		DATINION 1	Completed cause of deeth	11) 31	720 F	ARRA	BUT	AVE	E KAN	15/NG	TON	MD 208
Stat Registra		31. Dete filed (Month, Dey, Year) JAN 14	32. Registrar's	Signeture	arland	214						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** G. NOWICKI, SR. EDMUND 1998 January 12:00PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner VA Maryland Health Care System Perry Point Cecil If Under 1 Year | If Under 24 Hrs. Months | Deys | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dev. Yeer) Birthplece (State or Foreign Country) **Funeral** Months 1X M 2 F Yrs. 219-18-4900 **Director** 71 08/27/26 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Caroline Director MD 1 Yes 2 □ No Denton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 510 Kerr Avenue Apt. 4 21629 United States death Funera 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indien, Bleck. White, etc. ty Yes 2 No
If Yes, Give
Year or Detes: 43 - 46 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√☐ No Specify þ Specify: White 3€Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementery/Secondery (0-12) College (1-4or 5+) Utility Companies Gas Conversion Tech. A. Pages 1 end 2 shows a strong of Health end Mental H yrtant: if Item 27 is marked off inlury or other traumatic eve 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be John F. Nowicki Stella Eachbach P 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Joseph Nowicki/Son 510 Kerr Ave., Denton, MD 21629 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Date Department of Important: If it any injury or o 1 □XBurial 2 □ Cremetion 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore, MD Holly Hill Mem. Gard. 1/20 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Framptom-Hawkins-Eskow Funeral Mulan Eskew PO Box 43, Federalsburg, MD 21632 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) End stage Dementia unknown Examiner Due to (or es e consequence of): Physician/Medical Examiner Alcoholism unknown physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Due to (or es e consequence of): 98 esn ò signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? should page 2 has 1 ☐ Yes 2X No 1 Yes 2 No Division of Vital Physician: 25. Was cese referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Aftar this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred or Attanding 5 Pending investigation death. 1 Yes 2 No 2 Accident the eftar deat Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) filled in by 4 Homlcide 24 hours e Hospital 29a. Certifier Medicai 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) and menner es steted. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 1/17/98 187907 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 31. Dete filed (Month, Day, Year)
JAN 20 '98 VA Maryland Health Care System, Perry Point, MD Ibrahim Eid, M.D. 32. Registrer's Signeture State hie Lavidson-Randell Registrar

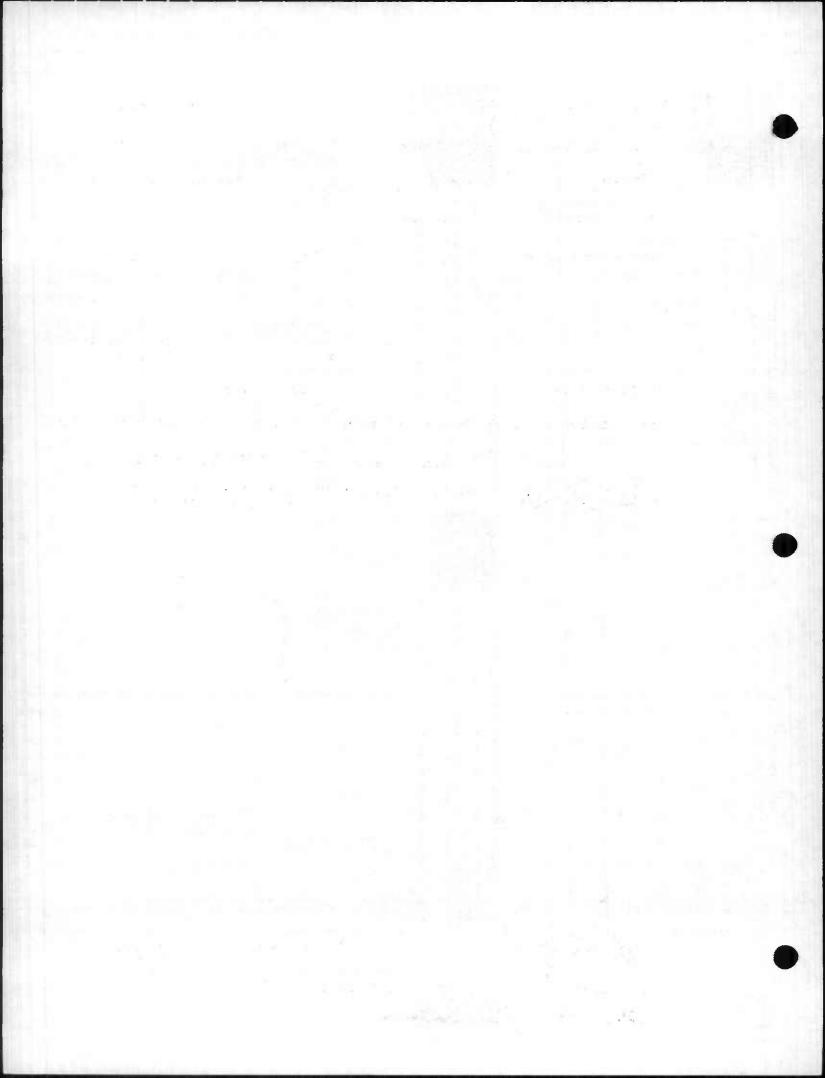
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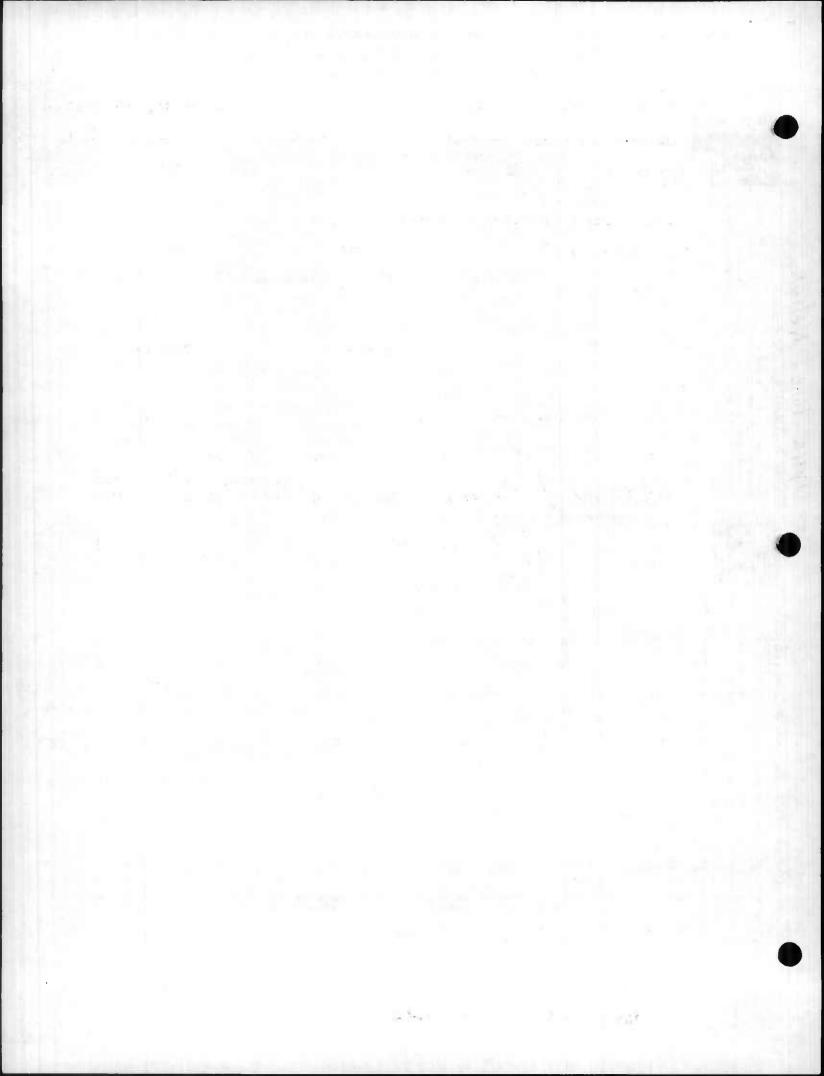
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neral ector	1	85-09-1 Usual Residence of	1035	6. Sex 1□	M 20XF	7. Age (In)	yrs. last birthde 87 Yrs.	Months Deys			7, Year) 3 1910	9. Birthp Cour PA	place (State or Foreigntry)
12	-	IOa. State	10b. Count	У		10c	City, Town or I	Location					0d. inside City Limits
tor		MD	Kei	nt			Galena	3					1 Yes 2010
lrec		loe, Street and Nur	mber					10f. Zip Code			10g. Citizen of \	What Cour	ntry?
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any injury or other traumatic event, the Medical Evanines must be notified at once. To Be Completed by Funeral Director		1. Meritei Stetus 1 □ Never Merri 3 ☑ Widowed		rried	12. Wes Dece Armed For 1 Yes If Yes, Giv Yeer or De	ces? 20 No	n U,S. 13	B. Wes Decedent of it Yes, specify Cul	Hispanic Origin? (S ben, Mexican, Puerl Specify:	Specify Yes or No- to Rican, etc.)		a - Americ ck, White, :: Whi	
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any ir		21, Signeture of Fu	neral Service	Upenso	20.	M00	510 G	22.Neme end Addr Salena F Box 235	uneral	Home of MD. 2		nen	Schaech
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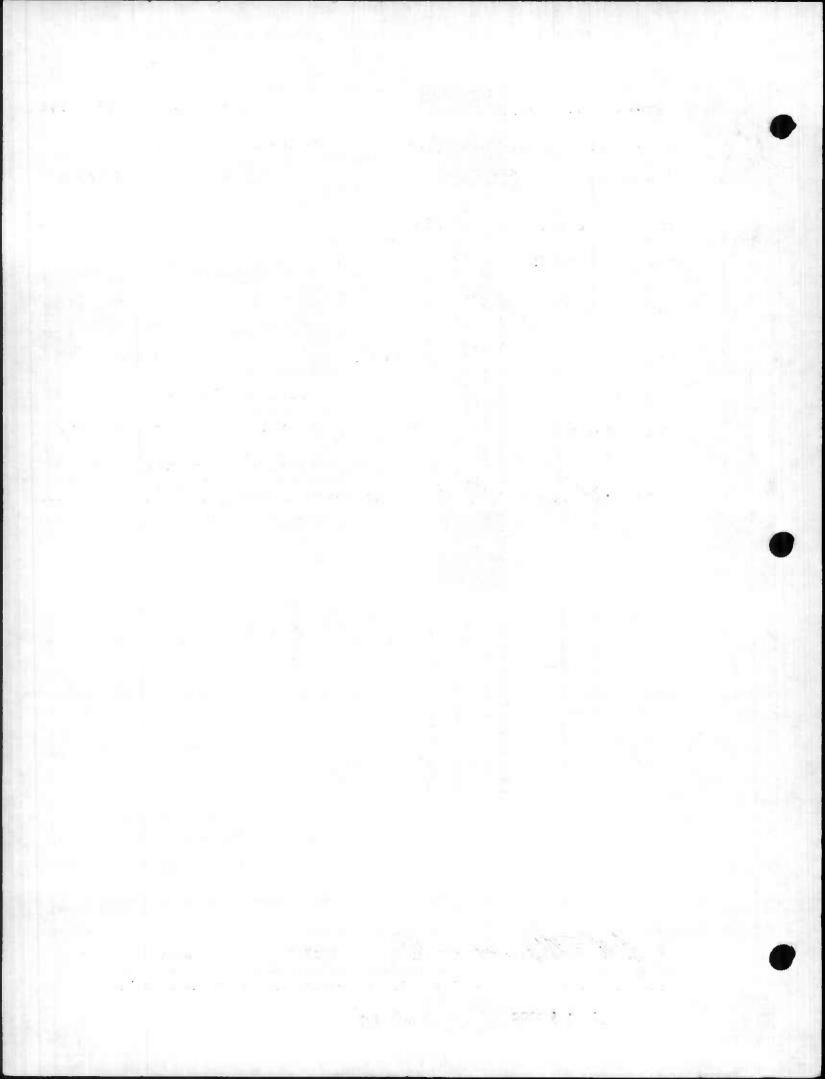
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th with th	unt be no	Funeral Director	10e. Street end Number 3106 Maygreen Aven	ue			10f. Zip	Coda 2074	7		10g. Cit	izan of Whet Cour A	itry?	
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Marnd 2 sho	traum		19a. Informent's Name/Reletionship (Type Charles Nelson, Sr						end Number or R ad Morni:			or Town, Stete, Zip 20746	Code)	
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altimore, altimore, mult. Pages 1 a partment of Heap portant: If item.	lury or		1 X Surial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emovei from S		edar H	ill Ce	emet	ery	1/14/98	17	land, Ma		
Baltimo	any in		21. Signeture of Funeral Service License **Duawara** J **Duawara** J	- Bri	axbn				ss of FacilityMA and Road			ERAL HOM Md 2074		
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of Vita Physician:	ō	2	1 ☐ Yes 2 ☐ No H			ER/Outpetie			4 Li Nuising i	Home 5 ☐ Res		6 Other (Specify	1)	
Vision Attending Pr death.	a fune	ation	1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident investigation	28e. Date of (Month	, Dey Year)	Injury	M Z	l8c. fnjur Wor 1 □	k? Yes 2 □ No	280. Describe	now injur	y occurred		
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Divisio To the Hospital or Attendit within 24 hours effer death. To the Funeral Director: A	completely filled in by the funeral	Medicai (29a. Certifier (Check only one) 1 Certifying Phys	Icfen: To the best and manne	sis of examine	owledge, dea etion end/or l	th occurred nvastigation	et the tir , in my o	ne, dete end pleco pinion, daath occi	e, end due to the urrad at the time,	ceuse(s) date end	end menner es st placa, end due to	eted. the ceuse(s)	
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61	7)		30. Name end eddress of person who cor	mpleted cause	of death /Item	n 23e) /Tuno	Print\	MA	140		//	10,98		_
	/		11 1 2 2	RZIN	750	75 5	Yeen	h	ay CF	R DK	· C.	Veer Gely	Mel 20270	
Re	Stat egistra		31. Dete filed (Month, Day, Year) JAN 1 5 1998	32 Re	gistrar's Signe	-Rardal	u							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene:

Dennett Road Manor Nursing Indiana Manor Nursing Indiana Nursing Home Dennett Road Manor Nursing Indiana Nurs			1. Decedent's Nam	a (First, Middla, L	ast)			tificate of		2. Data of De	ath	3. Tima of Dea
## Action years in order detactors, greates and columber of Carpert Season (Company Cases) ## Company Cases) Security Number Securit			ETHEL	MAY	OTTO						ry 9,	1998 8:45
9. Scelat Society Number 10. 19-56-98 10-9			4a. Facility Nama (If not institution, g	iva street and number	er)			4b. City, Town, or L	ocation of Death	4c. County	of Death
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30. Nama and address of parson who completed causa of death (Itam 23a) (Type, Print)	within 24 hours after death. To the Funeral Diractor: After the funeral principal points of the funeral principal points of the funeral points of the funeral points of the funeral points of the funeral points of the fun	edical	(Check only one)	2 Medical Exa	and mannar	0101001	111	29c. Licans	sa number		29d. Data signed	(Month, Day, Year)
	within 24 hours efter deeth. To the Funeral Diractor: After completely filled in by the fu	edical	(Check only one)	2 Medical Exa	4.		MP.					
	within 24 hours effer deeth. To the Funeral Diractor: Af completely filled in by the fu	edical	(Check only one) 29b. Signatura and	titla of pertifiar	Marine	en	_	D2				

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Name (First, Middle, Las	t)	1	001	tificate of	Douti	2. Dete of Deet			Time of Death
Physici /Medi		Fannie (Osterman					Month January	Day 9, 199	Yeer 98	9:45 am
Examir		4e. Facility Nema (If not institution, give		r)			4b. City, Town, or Lo	ocation of Death	4c. County	of Death	
	Ш	9408 Underwood Sti					Seabrook			e Georg	
Funeral Director		377-10-0031	9X 7. A □ M 2以F	iga (In yrs. I	last birthday) Yrs.	Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, Aug. 9,	^{Year)} 1920	9. Birthplace Country) Virgin	(State or Foreig
ms 23a or 28a-f show		Usual Residence of Decedent 10e. State 10b. County		10c. City	, Town or Loc	eation					Inside City Limits
a or 28a-f show be notified at	Director	Maryland Prince G	eorge's	Seal	brook					1	Yes 2□No
Or 2	Dire	10e. Street end Number				10f. Zip Code		11	0g. Citizen of V	hat Country?	
23	rai	9408 Underwood Str				20706			U.S.A.		
	by Funeral	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2X If Yes, Give Year or Dates:	? I No	It	Vas Decedent of F Yes, specify Cuba ☐ Yes 2 X No	dispento Origin? (Sp an, Maxicen, Puerto Specify:	ecity Yes or No- Rican, etc.)		e - Amarican Ir k, White, etc. White	
Hygiene. ther than *natural; or its ort, the Wed cal Examine	Completed	15. Decedent's Edu (Specify only highest grad Elementery/Secondery (0-12)	ucation de <i>completad)</i> College (1-4or	5+)	(Give k life. D		pation during most of work d)	ing	16b. Kind of Bu		у
other th	ပိ	12 17. Fathar's Name (First, Middla, Last)			Homema	iker	18. Mother's Name		Own Hom		
d o o	Be c	Raymond H. Money						ne Stien		θ)	
M Du M	2	19e. Informant's Name/Relationship (T	vpe. Print)		19b Malling	Address (Street	and Number or Run			State Zin Cod	(a)
		Bernard V. Osterma					Lane, Bow				,0)
the Heed		20a. Method of Disposition	ar Bon	20b. Pl	ace of Dispos	ition (Name of			20c. Location -		State
ont: If		1 X Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)		3		atory or other place oln Ceme		/13/98	Brentwo	od Ma	ruland
Department of Health (Important: If Item 27 is eny injury or other tra		21. Signature of Funeral Sarvice Licans		101	22. F1	Name and Addre	asch's So	ns Funer	al Home	, P.A.	- ·
		23a. Part 1. Enter the disease, or comp	ligations that squee	ud the death			imore Ave				
nysician		shock, or heart failure. List only o	ne ceuse on aach	line.	. Do not onta	Title mode of dys	ig, such es cardiac (or respiratory arra	iot,	Inte	proximate erval Between sat and Death
Medicai		Immediate Ceuse (Final disease or condition	5	noh	455m	A				1	lec
xaminer		resulting in deeth)	θ	Due to (d	s e consequ	enca of):				17	16
#	iner		b								
physician end the buriel-transit	Examiner	Sequantially list conditions, if any, laeding to immadiate cause. Enter Underlying Cause (Disease or injury Ihal initieted events	D	Due to (or	es e consequ	enca ot):					
D 10	edical	that initieted events resulting in death) Lest	c	Dua to (or	es a consequ	enca ot):					
e ettendin d for use	Physician/M		d								
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been signed by the ettending should be detached for use et	by Phy							1 □ Ye	s 2 No	3 Probably	4 Sonknov
es been signed b	Completed		3					24a. Was er perform	eutopsy led?	evailabl	utopsy findings le prior to tion of causa h?
pege 2	Son							1 ☐ Ye	s 200 No	1 ☐ Yes	s al No
certificate rector, peg	Be	25. Was case reterred to medical exeminer?	11				26. Plece of Death	h (Check only one	9)		
After this certifice funeral director, i	ion: To	27. Manner of Deeth	1 Inpati 28e. Date of Inj (Month, De	Urv	ER/Outpatient 28b. Time of Injury	28c. Injur Wor	4 LI Nursing no	me 5 Reside 28d. Describe ho	nca 6 □Othe w injury occurr		
within 24 hours efter deeth. To the Funeral Director: After this completely filled in by the funeral dir	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Pleca of In building, e	jury - At hor tc. (Specify	me, farm, stre	et, factory, office		28f. Location (Str City or Town	eat and Number, State)	er or Rural Rou	ute Number,
24 hours Funeral etely fille	edicai C	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	eicien: To the best ner: On the basis of and manner si	t examinat	viedge, death on and/or inve	occurred et the tinestigetion, in my o	ne, date and piece, pinion, death occurr	and due to the ce red at the time, da	use(s) end me te end place, e	nner as stated and due to the	l. cause(s)
ompl	₹ e	29b. Signeture and title of certifier	1			29c. Licens	e number	29	d. Date signed	(Month, Day,	Year)
		101	~			NI	9421				
3 F 0	- 1		1				1 1:31	J	anuary	9, 199	0
	-	30. Name and address of person	ombleted cause of	deeth /Itam	23a) (Tuno D	rint)	. 101				
6)		30. Name end address of person who co Frank Ryan, M.D.	/			•	Fort Wasl				

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death AX (ARGARE) ARHE 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth County of Daath MARI If Undar 24 Hrs. 8. Date of Birth Min. (Month, Day. LANC R If Under 1 Yeer 7. Age (In yrs. last birthday) 5. Social Sacurity Number 9. Birthplaca (Stata or Poraign Country) Months Days 1 M 2 TyF 83 Yrs 219-07-7426 February 21, 1914 Maryland Usual Rasidance of Decadent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 AYas 2 No Maryland Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9401 Tester Drive 20744 United States 12. Was Dacedent Ever In U,S. Armed Forcas? Was Dacedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. 11 Maritel Status 1 ☐ Navar Married 2 ☐ Married ☐ Yas 2 20No f Yas, Give 1□ Yas 2ENo Black lf Yas, Give Yaar or Datas: 3 Nidowed 4 Divorced 16e. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Homemaker Home 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Surnama) not known Emma Matilda Taylor 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Matilda Morton 9401 Tester Drive, Fort Washington, Maryland 20744 Daughter 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Spring Grove Cemetery 1/17/98 Denton, Maryland Funeral Service Licen 22. Name and Addrass of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 23a. Part1. Inter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarvel Batween Onset end Deet Immediata Cause (Final diseasa or condition rasulting in death) Dua to (or as a consequence of) Dua to (or as a consequence of): Dua to (or as a consequence of):

Physician /Medical Examiner

physician end s the buriel-transit

8 attending 0

the

signed by

peen hes page 2 certificate

this funeral

After

efter death.

within 24 hours e To the Funeral

in by the

completely

À

Completed

Be

2

Medical Certification:

P.O. Box 68760,

Division of Vital Records.

To the Hospital or Attending Physician: within 24 hours efter death.

requires that the death certificate be

Physician

/Medical

Examiner

10a, State

10

Director

Funeral

à

Completed

Be P

Funeral

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it a Maoical Exprisive must be notified at

pemit. Peges 1 and 2 should be filed within 7 Department of Heelth and Mental Hygiene, Important: If Item 27 is marked other than "n any Injury or other traumatic event

the Maryland

72 hours efter deeth

Baltimore, Maryland 21215-0020

Examine Sequantially list conditions, if any, leading to Immadiata causa. Entar Underlying Cause (Diseasa or Injury that initieted avants rasulting in deeth) Last Physician/Medical

29b. Signatura and titla of certifier

31. Data filad (Month, Day, Yaar)

JAN 15

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. mary Emboli-Chrowither Feral Failer diac Arrhythema.

23b. Did tobacco use contribute to the cause of deeth?

1 ☐ Yes 25 No 3 Probably 4 Unknown

24b. Wara autopsy findings availabla prior to complation of cause of daath? 24a. Was an autopsy

2/N No 1 ☐ Yas

26. Placa of Death (Check only ona)

1 ☐ Yas 2 ☐ No

25. Wes casa rafarrad to madical examinar? Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Tima of 28d. Dascribe how Injury occurred

28e. Data of Injury (Month, Day Yaar) 28c. Injury at Work? 5 Pending Invastigation 1 Vatural 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida

6 Could not be determined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

Descripting Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner es stated.

| Medical Examiner: On the best of examination and/or investination in my opinion death occurred at the time, date and place. 29a. Certifian dical Examiner: On the besis of axamination end/or invastigation, in my opinion, death occurred at the time, deta and place, end due to the causa(s) and manner stated.

29c. Licansa number

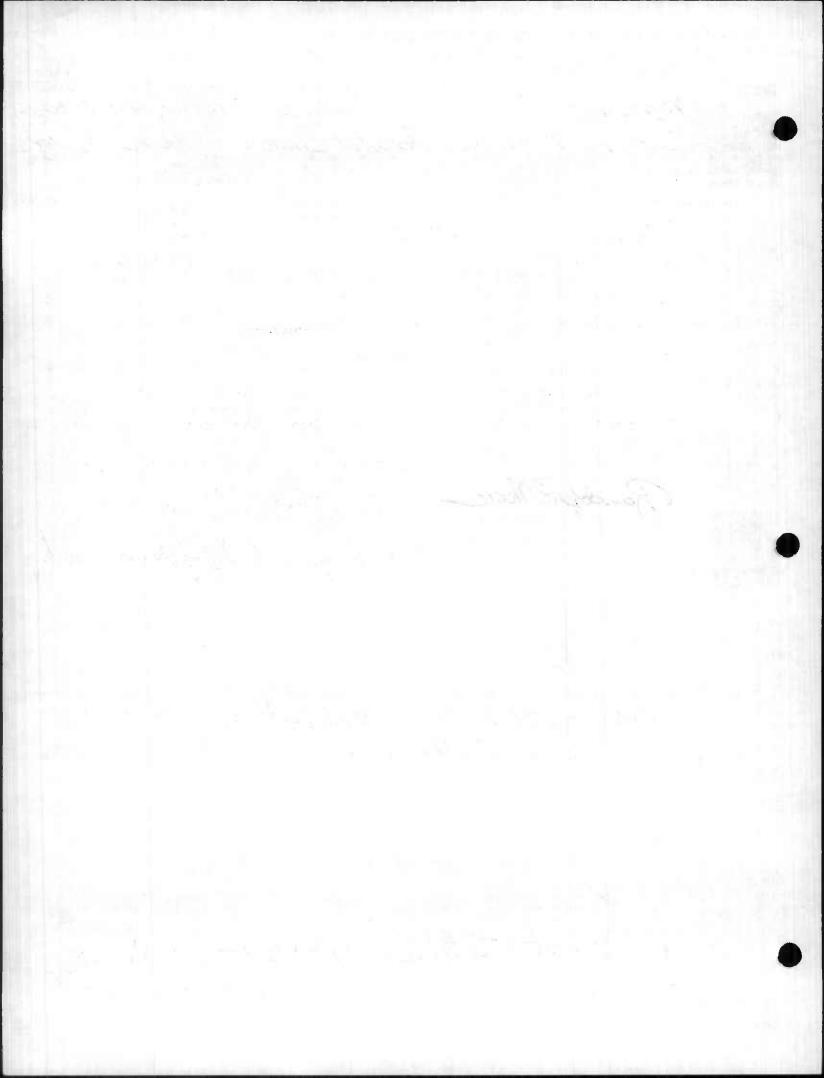
29d. Data signed (Month, Day, Year)

30. Nama and eddrass of person who complated causa of deeth (Itam 23a) (Type, Print)

20735

State Registrar

Essam Tellawi, M.D., 7700 Old Branch Avenue, STEB-102, Clinton, MD 32. Registrar's Signatura Pandell Sulia Davidson



WRC 98-0256-033 HOLLY ANN

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State of Maryland / Department of Health and Mental Hygiene

29d. Date signed (Month, Dey, Year)

JAN. 17, 1998

PATE					Certifica	ate of	Death		Reg. No.	023	4		
	sician	Decedent's Name (First, Middle, La Holly Ann Pat					2. Dete of D Month JAN			me of Deeth			
le .	edical miner	4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth											
LAG	iiiiici	PRINCE GEORGES HOSPITAL					CHEV	ERLY	Princ	ce Geor	ae		
Fune	ral	5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Bit								9. Birthpiece (S Country)			
Direct		216-08-8953 One of December 10 M 2 Property 25 10 M 2 Prope											
Merylenc n=f show		10a. Stete 10b. County 10c. City, Town or Location 10d									Ide City Limits		
	tor	Maryland Charles Waldorf								1	Yes 2 No		
th the	lre(10e. Street end Number				10f, Zip Code				10g. Citizen of What Country?			
and 21215-0020 be filed within 72 hours efter death with the Meryland ritel Hygiene. Ind other than "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at	<u>a</u>	2064 Tangle Wood Drive 20601					1	U.S.A			.A.		
	Funeral Director	11. Maritel Status	12. Was Decedent Armed Forces?		13. Wes De If Yes, s	Ves Decedent of Hispenic Origin? (Specify Yes or No Yes, specify Cuban, Mexican, Puerto Rican, etc.)			No- 14. Race - American Indien, Bleck, White, etc.				
	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes	1 ☐ Yes 2 ☐ No Specify:			Specify: White				
	0	3 Widowed 4 Divorced	Year or Dates:	- Danadantia II	A			16b. Kind of Bu					
	Completed	15. Decedent's E (Specify only highest gr	ade completed)	completed) (Given life.		dent's Usuel Occupation a kind of work done during most of working DO NOT use retired)			160. Kind of 80	ismess/moustry			
	E O	Elementery/Secondery (0-12)	College (1-4or s	College (1-4or 5+) Home					Her Home				
aryland 2 should be filed and Mentel Hygis marked other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middl	e, Meiden Sumem	ne)			
arylan should be nd Mentel marked o	ToB	Howard L. Matt	hews	ews			Mildred L.			Nelson			
Maryland of 2 should be file the end Mentel Hy 27 le marked other traumatic event		19a. Informent's Name/Relationship	Type, Print)	ype, Print) 19b. Meiling Add				r Rurel Route Num	ber, City or Town,	City or Town, State, Zip Code)			
Baitimore, Maryla pemit. Pages 1 end 2 should Depertment of Health and Men Important: If Item 27 le marke any Injury or other treumstic		Mildred L. Lane Mother 6245 Mildred Place, LaPlata, Md. 20646											
		20a. Method of Disposition 1											
Itir Pulit. Portan													
	puce	Williams Funeral Home, P.A.											
		M00668 4270 Hawthorne Rd., Indian Head, Md.2064 23a. Part Enter the resease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, Shock, or heart failure. List only one cause on each line. Approximate Intervel Between											
	an l	shock, or heart failure. List only one cause on each line. Interval Between Onset end Deeth											
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BOX ath cer	Physician/M												
O. Bo e death the etter	SIC	Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 540 3 Probably 4 Unknown											
cords, P.O. Box requires that the death cer been signed by the ettendir should be deteched for use	Ph												
	by							040 14/4		24b. Were eut	oney findinge		
Record ne law require s hes been si	Completed								24e. Wes en eutopsy performed?		prior to on of cause		
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Division or Attanding efter death. Director: After	ertification:	2 ☐ Accident investigation 3 ☑ Suicide 6 ☐ Could not be	0		00/		, .03 2 140	SUS/		per or Rural Route	Number		
Div	itte	4 ☐ Hornicide determined	building et	28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)				City or T	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)				
1 2 2 2 9 9 b	Ö							2051	2051 Hawthorne Rd				

State Registrar

Medical

29a. Certifier (Check only one)

David

29b. Signature end title of certifier

Power 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jalia Davidson Randall

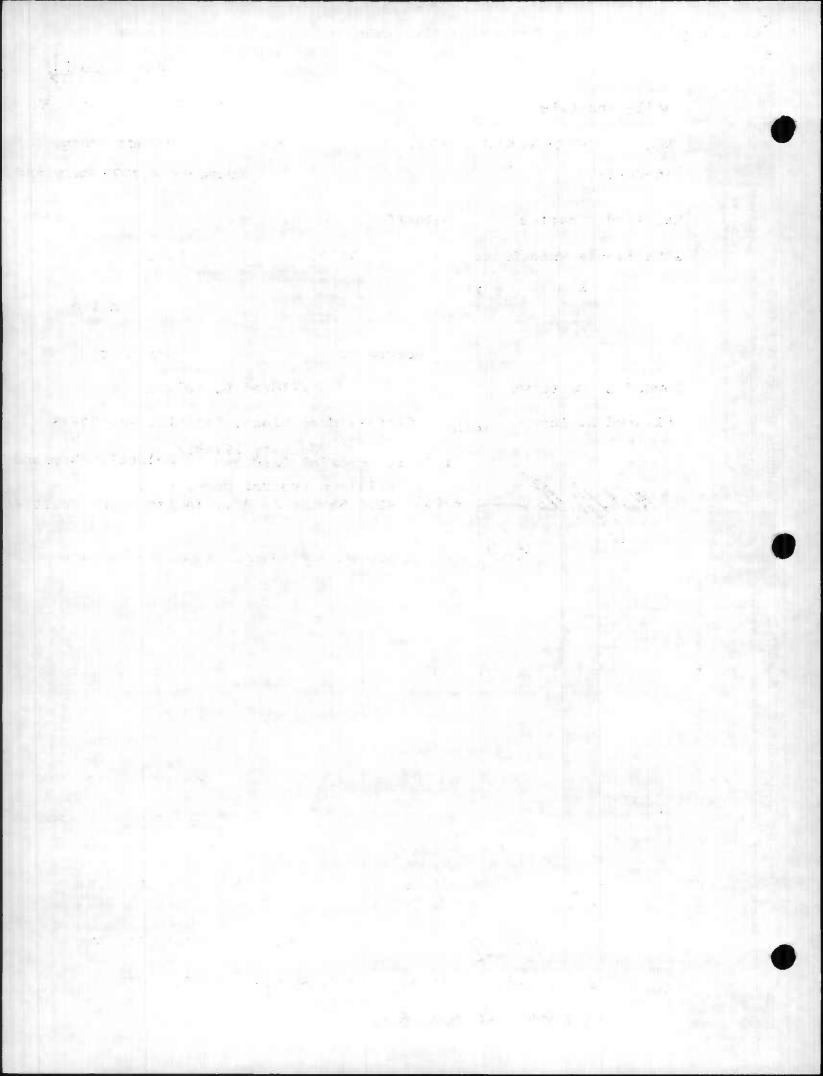
1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner as steted.

27 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner steted.

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiens

	1. Decedent's Neme (First, Middle, Last)						2. Date of De			3. Time of Death	
Physician	Charles L	Charles L. Perrygo						Y 09	Year 1998	10:31a.m	
/Medical Examiner							JANUAR Location of Daat		y of Death	10.514.11	
EXMIIII CI	Saint Mary's Hospital Leonar										
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yaar 1				If Under 24 Hrs						
Director	Months Days Hours Min, (Month, Day, Year) Col						Washi	lace (State or Forai try) .ngton, D.			
ed st	10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Li								0d. Inside City LImit		
be notified Director	Maryland St. M	ary's		Leonard							
D R	D. O. D. O.	D			Of. Zip Code		V	10g. Citizen ot		try?	
a la					20650			U.S.A.			
the Medical Exercises rount be notified at ompleted by Funeral Director	3 Midowed 4 □ Divorced	Armed Forces? 1 Naver Marriad 2 Married 1 Yes 2 No			Yes 2 No		rto Rican, etc.) Blac		ice - American Indien, ack, White, etc. ify: White		
i e	15. Decedent' (Specify only highest	1	6e. Decedent	's Usual Occup	petion	16b. Ki		Kind of Business/Industry			
To Be Completed	Elementary/Secondary (0-12)	+)	16e. Decedent's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT use retired) Policeman				Prince George's Count				
BeC	17. Father's Name (First, Middle, L	ast)				18. Mother's Na	ne (First, Middle				
0 8	Elmer Perryg	0				Rose	Kesters	son			
-	19a. Informent's Neme/Relationsh	ip (Type, Print)		19b. Meiling A	ddress (Street	and Numbar or Ru	ıral Route Numh	er, City or Town	State. Zin	Code)	
other traumatic	Bruce Perrygo/					Cove Lane					
3	20a. Method of Disposition		20b. Plac	e of Disposition of Disposition of Disposition of Disposition of the D	n (Nama of	ove rane	Date	20c. Location	- City or Tov	wn, State	
any injury or o	1 Burial 2 □ Cramation 4 □ Donetion 5 □ Other (Sp.		St R	erary, cremato arnahae	churc	h Cem.	1/12/98				
		**	DC.D				1/12/98 Temple Hills, Md.				
onc	21. Signature of Funeral Service Licenties 22. Name end Address of Facility George P. Kalas Funeral Home										
	23a. Pert1. Enter the diplose, or c shock, or haart tajj e. List o	Track	11	616	0 Oxon	Hill Rd	. Oxon F	Hill. Md	L 207	45	
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Examiner	Immediate Causa (Final disease or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
<u>20</u>											
as the burial-transit											
Se a	a Diabetes Mely L										
1 E	Chris send lusuff										
Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of deatl					
by Ph											
Completed							24e. Was	en eutopsy ormed?	eva	re eutopsy findings ilable prior to apletion of cause leath?	
Page CO							10	Yes 2 No	10	Yes 2□ No	
Be Be	25. Wes casa reterred to medical examiner?					28. Place of Dea	th (Check only o	one)			
To To	Hospitel:						Home 5 Residence 8 □Other (Specify)				
nara on:	27. Menner of Death 1 ☑Naturel 5 ☐ Pending	28a. Date of Injury	28a. Date of Injury (Month, Day Year) 28b. Time of tnjury 28c. Injury at Work?			y at	28d. Describe how injury occurred				
Certification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined determined						28t. Location (Street and Number or Rural Route Number,				
Cerl											
Y B	29e. Certifier (Check only one) 1D Certifying Phyaician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of exemination and/or investigation, in my opinion, death occurred at the lime, date end place, end due to tha ceuse(s) end menner stated.										
et p	290. Signature and title of children 29c. Licensa number							29d. Date signe	d (Month, D	Day, Year)	
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Complate	10	-	ath (Itam 22	a) (Tyno Print	D-150	032		January	9, 1	.998	
To the Funeral Director: After this cardificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use Medical Certification: To Be Completed by Physician/N	30. Name and address of person will V. K. Shah, M.	no completed cause of de)		arvland		9, 1	.998	



32. Registrar's Signeture

Like Shideer Rarlett

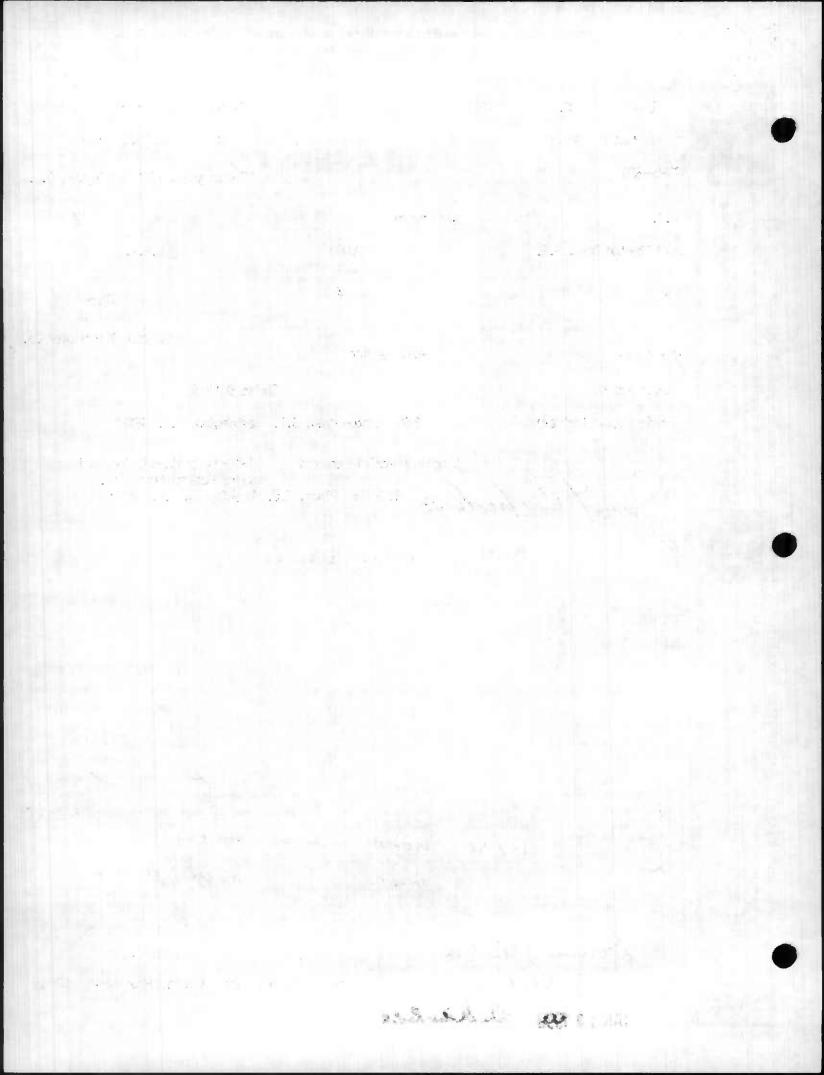
DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 8 1998



State of Maryland / Department of Health and Mental Hygiene

Physician		1. Decedent's Nem			PIERCE							2. Dete of Dee Month	Dey	Year	3. Time of Dea
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Examiner	r				street ena num	ber)									ORGE S
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	5	0 E2 111001100	15. Decede			65.	16e	Decedent's	Usual Occu	netion			16b. Kind of B	usiness/in	dustry
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ent, me M	3	17. Fether's Neme	(First, Middle	e Last)						18 Mother's	Name /	First Middle	Maiden Suman	ne)	
	Ď	FLOYD H		o, zaot,						ORLI		BROWN	on con connain	10)	
T is marked other traumatic event, I To Be Co	-	19e. Informent's N	eme/Relation	nship (Tv	rpe. Print)		19b.	Meiling Ad	dress (Stree				r, City or Town,	State. Zir.	Code)
27 is		WANDA P								RD ST.		LINGTON		2220	-
Important: If item 27 any injury or other tr once.		20e. Method of Dis	sposition			20b.	Piece of	Disposition	(Neme of	ana)		Dete	20c. Location -	City or To	own, State
ortant: If Injury or 9.		1 Burial 2 4 Donation			Removel from S	tere			N CEM		1/	10/98	BLADEN	SBIIRO	G. MD.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Yeer Theodore Lee Patterson Jr. 9, 1998 4c. County of Deeth 4b. City, Town, or Location of Death 2:55pm 4e. Fecility Neme (If not institution, give street end number) Cheverly MD PG If Under 1 Year if Under 24 Hrs. Months Deys Hours Min. 8. Dete of Birth (Month, Dey, Year) 1/20/21 7. Age (In yrs. last birthday) 1⊠M 2□ F 76 Yrs. Virginia 10b. County 10c. City, Town or Location PG Greenbelt 10g. Citizen of Whet Country? 10f. Zip Code 20770 USA 12. Wes Decedent Ever in U,S. Amped Forces? 1 △ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: Black 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+)

To Re Complete	P.	Medical Certification: To Be Completed by Physician/Medical Examiner	
permit. Pages 1 and 2 should be filed within 72 h Department of Heelih and Mentel Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, The Medical Once.	Physician /Medical Examiner	To the Hospital or Attanding Physician: The law requires thet the death certificate be executed within & Lours after death. To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detected for use as the burlel-transit	6)
Baltimore, Maryland 21215-(Division of Vital Records, P.O. Box 68760,	

Physician

Funeral

Director

28a-f show

r is marked other than "natural", or frams 23a or 28a-f shot traumetic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

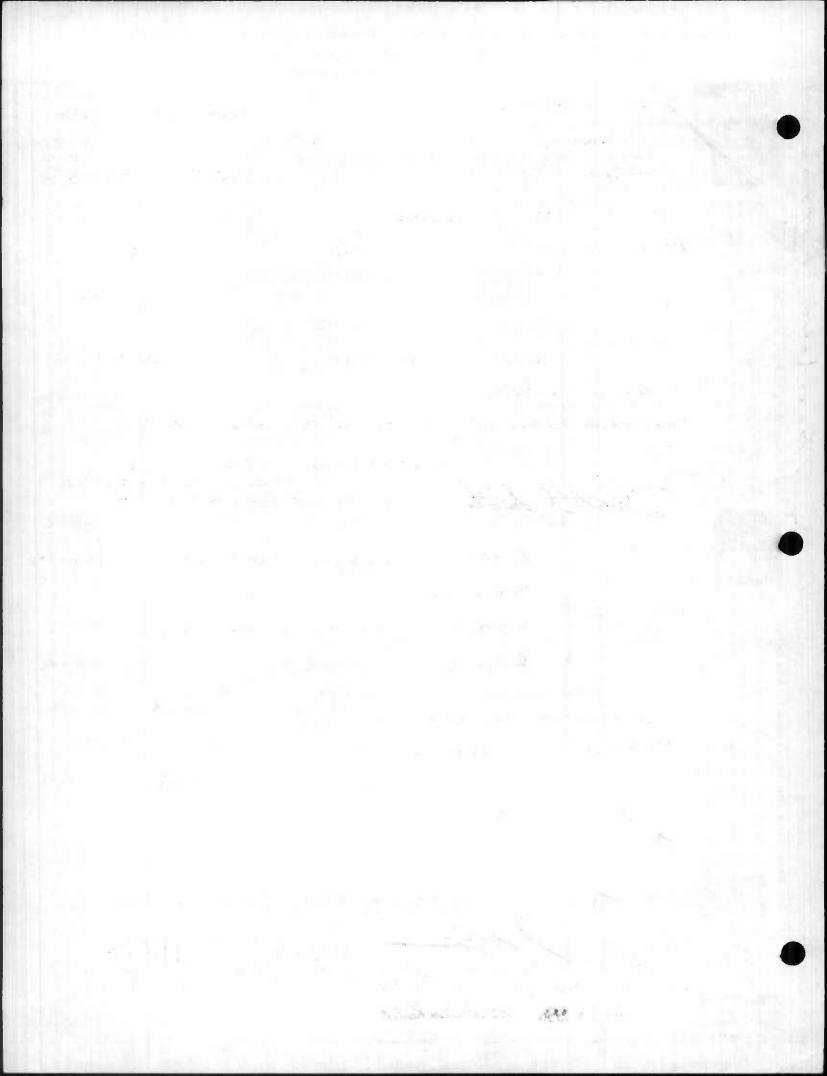
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/Medical

Examiner Doctor's Community Hospital 5. Social Security Number Birthplece (State or Foreign Country) 227-14-7125 Usuel Residence of Decedent 10a Stete 10d. Inside City Limits MD 1 Yes 2 □ No Director 10e. Street end Number 7341 Morrison Drive Funeral 1 ☐ Never Merried 2 ☐ Married by 3 ₩ Widowed 4 Divorcad Completed 15. Decadent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12±5± School Administrator DC Public School 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Theodore L. Patterson Sr Lillie B. Pannell 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) John Patterson/Brother 6528 N. Gratz St Philadelphia, PA 19126 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removei from Stete 20b. Piaca of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 4 ☐ Donetion 5 ☐ Other (Specify) 1/15/98 Triangle VA Quantico National 22. Name and Address of Facility Robert G. Mason Funeral Home 21. Signeture of Funeral Service License 1661 Good Hope Rd SE, Wash DC 20020 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Onset end Death Immediete Ceuse (Final disease or condition resulting in death) · CARDIORESPIRATURY BRINEST MINUTER Due to (or es e consequence of): SEPSIC 2700 Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest HENALOND SYRO AND MUSCLE NECZUSIS Due to (or es e consequenca of): RENAI WERKE I AILURE Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CARCINOMA OF STATE 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? EGSENTIAL HYPERTENSION 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 patient 2 □ ER/Outpetient 3 □ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Deeth 1 ☐ Natural 2 ☐ Accident 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Tertifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and placa, end due to the ceuse(s) and menner stated. 29a. Certifler (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number 30. Neme end address of person who completed 31. Dete filed (Month, Dey, Year) State JAN 14. 1998 Registrar



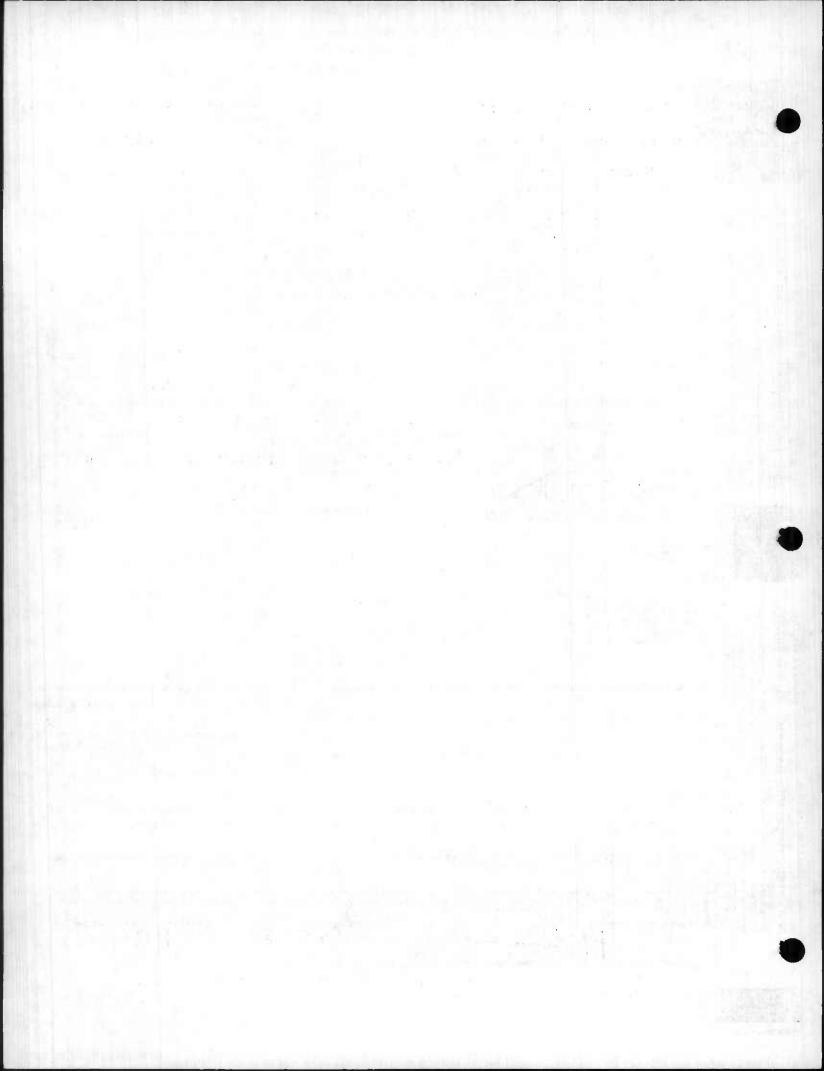
State of Maryland / Department of Health and Mental Hygiene 3

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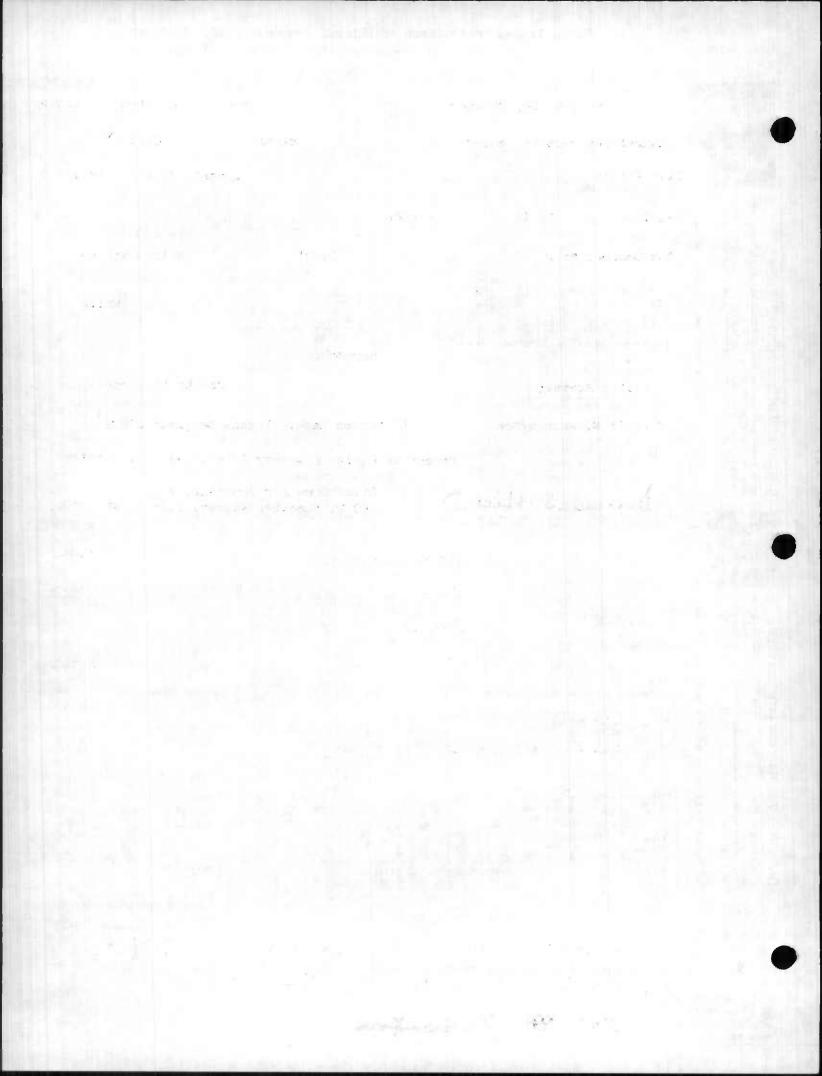
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yland		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Ba-fal	Director	WV Presto	n	H	lorseshoe R	un			1 ☐ Yes 2 💢 No
vith th	Dire	10e. Street end Number			10f. Zip Code		10	0g. Citizen of What C	country?
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Maryland 21215-0020 d 2 should be filed within 72 hours eff th end Mental Hyglene. ?? Is marked other than "natural", or treurmetic event, the Modical Evann	1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	No 1941–45	1 ☐ Yes 2 🙀 No	Specify:		Specify:	White
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end and and and and and and and and and a		Mark E. Raia/Son			25 Pennsylv	ania Ave.	, Charle	ston, WV	25302
Permit. Pages 1 er Department of Hea mportant: If Item 2 iny Injury or other Dice.		20a. Method of Disposition 1 Buriel 2 □ Cremetion 3 □	Removel from State	como to n	Disposition (Name of cremetory or other pla	ce)	Dete 2	20c. Location - City o	r Town, Stete
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		30. Name end eddress of person who c				0-1-11	Manus 1 1	21550	
-		Dr. Thomas John:		311 N. Fo	ourth St.,	vakland,	maryland	21550	
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D. Ko	Marital Status t ☐ Never Marriec 3 🖾 Widowed 4		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		If.	/as Decedent Yes, specify (☐ Yes 2[☑]	of Hispanic Origin? Cuban, Mexican, Pu No Specify:	(Specify Yes erto Rican, et	or No- c.)		- American li k, White, etc. White		
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17. I	8 Father's Name (F	First, Middle, Last)				пошеша	18. Mother's h	Name (First, M	liddle, Maid	ten Sumame	e)		
17.1	Walte	r Stewar	t					M	artha	Hitch	ncock		
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	Francis	N. Warr	en/Son		138	Herron	Lane, El	kton,	Maryl	and 2	1921		
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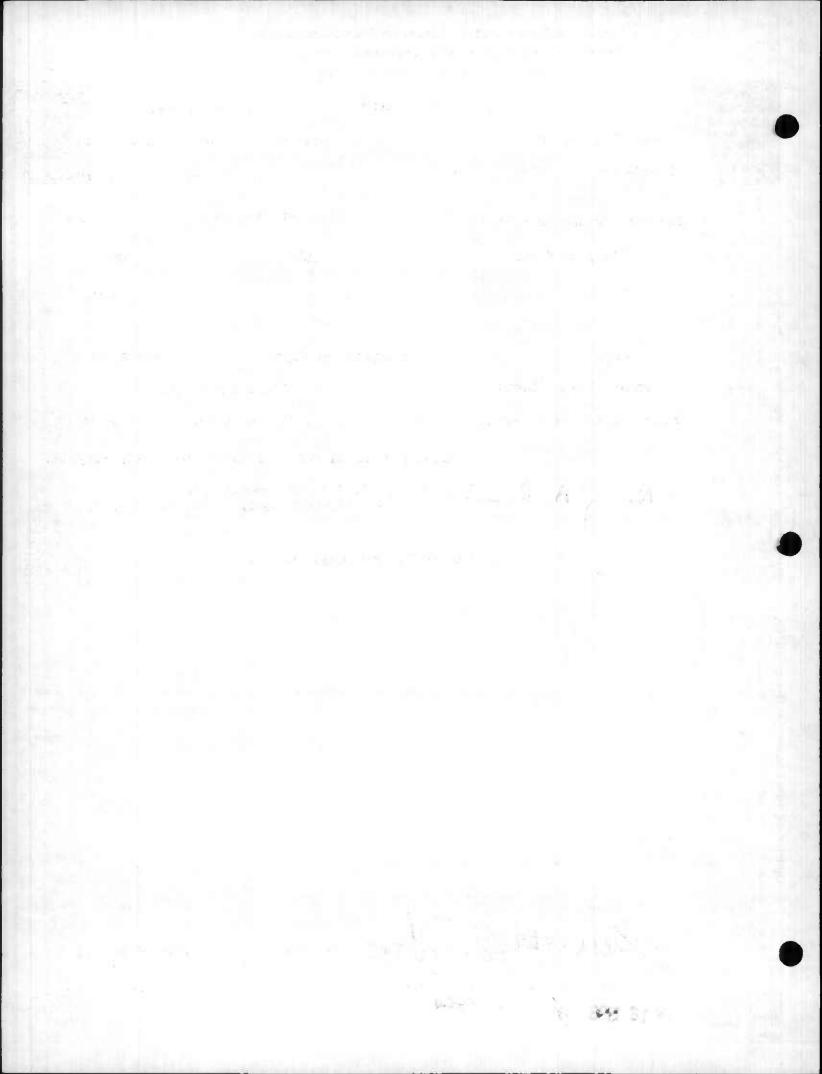
Julia Davidson-Rondoll

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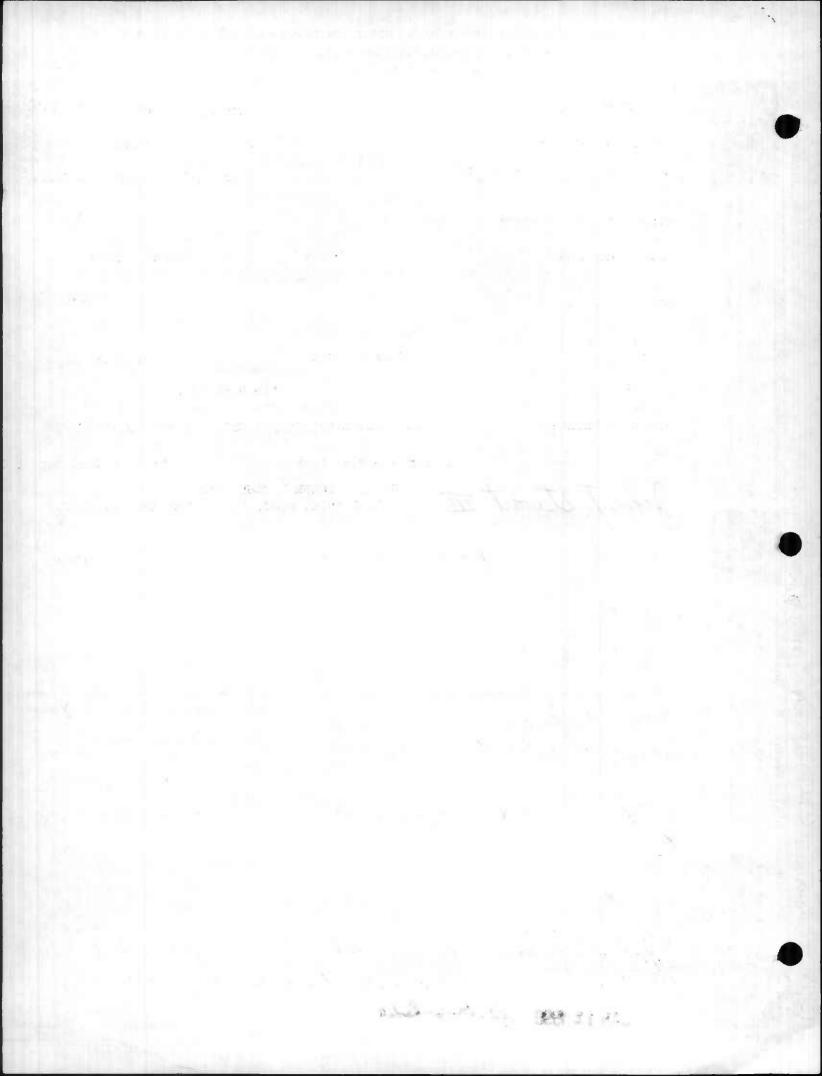


State of Maryland / Department of Health and Mental Hygiene 98 02349

D11-1-					Certifica	te of Death		Reg. No.	0 0 2 3	1 4
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Physicia /Medica	al .	Jeannett		≥ Rol	binson	,	Janua	-		und
Examine	er	4e. Fecility Nama (If not institution, git 4013 24th Pla	Company of the same of the sam				or Location of Deet est Height			1-
uneral irector		5. Social Sacurity Number 6.		yrs. last bir	thday) If Unde Yrs. Months	r 1 Year If Undar 24		th ly, Year)	ce George 9. Birthplace (Sta Country) Pennsylva	te or Foraig
		Usual Rasidance of Decedant							CIMIDYTVO	IIIu
show a		10a. Steta 10b. County		c. City, Town	n or Location	Willarock	Hairbta		10d. Inside	
offine of the	octo		George's			Hillcrest	neights		21	as 2□N
23a or 2	Funeral Director	10e. Street and Number 4013 24th	Place		10f. Zi	20748		10g. Citizan of V	Whet Country?	
	2	11. Marital Status 1 □ Nevar Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedant Eva Armad Forcas? 1 ☐ Yas 2 ☑ No If Yas, Give Yaar or Datas:	r in U,S.		dant of Hispenic Origin ecity Cuben, Maxicen, P 2X No Specify:	? (Specify Yas or No ruerto Rican, atc.)		e - American Indian ck, Whita, atc. : Black	
dical	etec	15. Decedant's E (Spacify only highest gr	ducetion	16a.	Dacedant's Usu	al Occupation	working	16b. Kind of Bu	usiness/Industry	
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tic e	2	Leonard Edwar	d Davis			Ве	ernice Arr	ington		
E M		19a. Informent's Name/Ralationship (-	s (Street end Number o				
or tru	1	Leonard E. Robins	on/Husband	40	13 24th	Place, Hil	lcrest He	eights, l	MD 20748	
nt: If item ry or oth		20a. Mathod of Disposition 1 ⊠ Burial 2 □ Cramation 3 □ 4 □ Donetion 5 □ Other (Specia	Ramoval from State	cemeter	Disposition (Na y, crematory or ny Memo)	ma of other place) rial Park	Deta 1/16/98		City or Town, Stata	
Importa any inju once.		21. Signeture of Funerel Service Lice	nsaa D +			nd Address of Fecility Jenkins F	uneral Ho	me		
hysicia tha bur	hysician and tha buriel-transit	disaasa or condition rasulting in deeth) Sequantially list conditions, if any, laading to Immadiate cause. Enter Undarlying Cause (Diseasa or Injury that initiated avants rasulting in death) Last	b	to (or as a c	consequence of)	:	sease			
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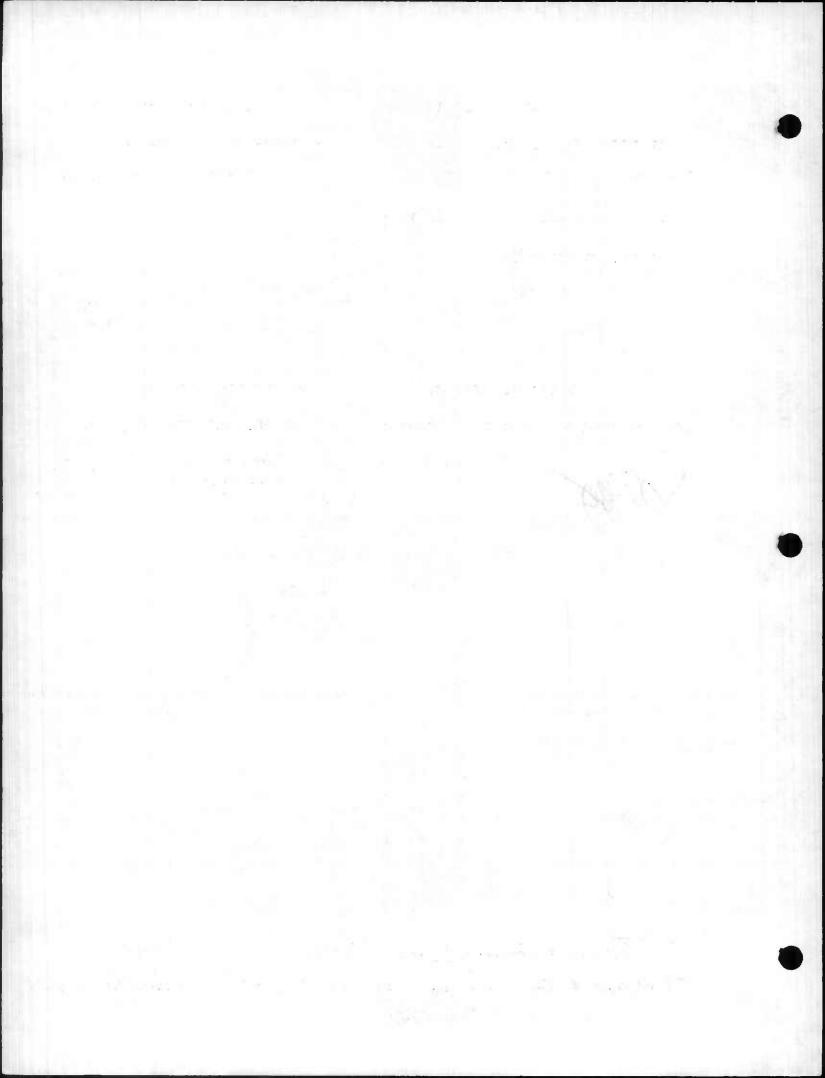


					ate of ivi	arylariu /		tificate of	Death		Reg. No.	0.7	2350
	Physic	ian	Decedent's Name (First, Mich.	idle, Last)						2. Dete of De Month	Dey	Year	3. Time of Death
	/Medi		CLASTINE H	RAYNOR						January			8:01 P.M.
	Exami		4e. Fecility Name (If not institut	ion, give street	and number)				4b. City, Town, or Lo	ocation of Deet	h 4c. County	of Death	
			SUBURBAN HO	SPITAL					Betheso	la	Mon	tgom	erv
1000	Funeral		5. Social Security Number	6. Sex		e (In yrs. last t	oirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da		-	place (State or Foreign
	Director		246-28-9053 Usual Residence of Decedent	1□M 2	F	86	Yrs.	Months Days	Hours Min.	July 22			Co., N.C.
	and and		10a. Stete 10b. Coun	ty		10c. City, To	wn or Loc	ation				1	10d. Inside City Limits
	Manylan f ahow	ō	Maryland Prince	e George	010	TOT	mla	Hills					1 XYes 2 No
	with the Marylar s or 28s-f show be notified at	Director	10e. Street and Number	ocor 9	- 5	101	прте	10f. Zip Code			10g. Citizen of ¹	What Cour	nto O
	Will Will		2207 Dawn L						7.40				•
	se 23a	era			as Decedent	Francis II C	40.14		748		United		
21215-0020	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or itsms 23s or 28s-f show int, the Medical Examinet mant be morified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorce	Arried 1[med Forces? Yes 251 Yes, Give			Yes, specify Cub	Hispenic Origin? (Sp en, Mexican, Puerto Specify:	Rican, etc.)	Specify	ck, White,	can Indian, etc. Black
Õ	72 hor	0	15. Decede	ent's Education		16	a. Deced	ent's Usual Occup	pation		16b. Kind of B	usiness/In	dustry
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9	be filed ntal Hygi ed other event, I	O	17. Father's Neme (First, Middle	e, Last)			110	nzeveeht	18. Mother's Nam	e (First, Middle		rivat	:e
an	d be sontal	o Be	Unknown										
_ ≥	2 should be for and Mental I is marked of	2	19a. Informant's Name/Relation	nchin /Timo Pr	in el	40	Mr. Mailine	n Address /Ctrass	t and Number or Run	Highsn		C4-4- 7/-	0-41
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a)	f Health f Health ftern 27 I		Alice P. Wil 20a. Method of Disposition	llams		20h Place	207	Dawn Lan	e, Temple				
or	T It		t⊠Burial 2 ☐ Cremation	3 □Remova	al from State	cemet	ery, crem	atory or other pla	ica)	Date	20c. Location	City or 10	own, State
Baltimore, Maryland	permit. Pagas 1 en Department of Haal Important: If Item 2 any Injury or other <u>once</u> .		4 Donation 5 Other	(Specify)		Carv	er M	emorial	Park 1	1/17/98	Mou	nt Ol	Live, N.C.
a	Departiment Important In In In In In In In In In In In In In		21. Signature of Funeral Service	e Licensee	1.		22.	Name end Addre	ess of Facility UNERAL HO	MD Too			
0	205 2 3		John /	XTaur	MIT	711			ing Road,				D 0
CF		7	234 11. Enter the disease, nock, or heart failure. Li	or complication	s that caused	the death. Do	not ente	r the mode of dyi	ng, such as cardiac	or respiretory e	rrest,	gron,	Approximate
	Physician		prioce, or neart failure. Li	st only one cau	se on each III	ne.						i	Interval Between Onset and Death
	/Medical		Immediate Ceuse (Final		P	1		,					1.
	Examiner		disease or condition resulting in death)	8		new	m	*					day
3		ē				Due to (or as a	a consequ	ience of):				į	
50	uted Insit	dical Examiner		b				F					
1998 8 3 68760,	The lew requires thet the death certificate be axecuted ate hes been signed by the attending physician and page 2 should be detached for use as the burial-transit	xa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury			Due to (or as a	consequ	ienca of):				į	
1998 E	be	B	Cause. Enter Underlying Cause (Disease or injury that Initiated events	C								-	
85 78 78	phys phys	B	resulting in death) Lest	1		Due to (or es e	consequ	enca of):				į	
So Xo	aath cartif attending for usa a	N		d								1	
Bo	atten for u	Physician/M										1	
40	the di	ysi	Part II. Other significant condit				In the un	derlying cause given	ven in Part I.	23b. Dld	tobecco uee co	ntribute to	o the cause of death?
/ 4	thet tha de ed by the detached	P	Renal F.	ulun						10	Yes 2 No	3 Pro	bably 4 Unknown
9 5	w raquires thet been signed k should be det	by				1						T	Constitution and a second
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Jasyne Vital Records		Bec	25. Was case referred to medic	al					26. Place of Deat	h (Check only	one)	1	
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0	g Phys ar this aral di		27. Menner of Death		. Dete of Inju	ry 28b.	Time of	28c. Inju			how injury occur		,,
0	Attending Phir daath. ector: Aftar thi by tha funaral	tio	1 Naturel 5 Pend 2 Accident inves	ling tigation	(Month, Day	y Year)	Injury		Yes 2 □ No				
15	Attendi er daath. ector: A by tha fi	fice	3 ☐ Suicide 6 ☐ Coul	d not be 28e	. Place of Inju	ury - At home,	farm, stre	et, factory, office				er or Rure	al Route Number,
Andr, Division	efte Dire	Certification:	4 Homicide		building, etc	c. (Specify)				City or To			
raynor, Divisio	To the Hospital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	edical C	(Uneck only 2 Medica	il Examiner: O	n the basis of	examination a	ge, death	occurred et the the	me, date and placa, opinion, death occurr	and due to the	cause(s) end ma	anner es s	tated.
a	the the	Med	one)	ar er	nd manner ste	eted.							
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	5		pe of	unh	~ /	14.0		W2	05/6		Jan 9	199	8
10 5	121		30. Name and eddress of perso		ed cause of d	eath (Item 23a) (Type, P	Print)	A 1 3 1	- 6			
5-6	0/		Moel Scha	man	9411	0/4/0	Pors	stown 1	RV Both	ev 6 14	0 208	14	
200	Sta	ite	31. Date filed (Month, Day, Yea		32. Registre	ar's Signature	0 .	44	-				
_ 00	Registr	ar	JAN 12	1998	Malia	a Problem	Martin	耳					
					-								



State of Maryland / Department of Health and Mental Hygiene 9 8

						C	ertificate of	Death		Reg. N	90	U	233	1
Discont	-:	1. Decedent's Neme (First, Mic	idle, Last)						2. Dete of D	eeth		/eer	3. Time of	Death
Physi /Med			DOUG	GLAS DA	VID R	нот	EN		JAN.	14,	1998	3	7:00	AM.
Exam		4e. Fecility Name (If not institu	ion, give s	street and numbe	or)			4b. City, Town, or	Location of Dea	ith 4	c. County of	Deeth		
		2201 FRIZZE	+					WESTMIN	_		CARI			
Funera Directo	_	5. Social Security Number 214-36-8257	6. Sax	M 2□F	Age (In yrs. la	st birthd Yrs	Months Day			irth Pay, Year 738			laca (Stata o try) LAND	
and **		Usual Rasidenca of Decedent 10e. State 10b. Cour	ity		10c. City,	Town or	Location					10	0d. Inside Ci	ity Limits
he Mery 8a-f sho	Director		ROLI		W	EST	MINSTER						1 ☐ Yes	
deeth with the Meryland ms 23a or 28a-f show	ral Dire	10e. Street and Number 2201 FRIZZE	LBUR	G RD.			10f. Zip Code 2115	8		U	itizen of Wh	et Count	iry?	
or its	by Funeral	11. Marital Status 1 □ Nevar Merried 2 ☑ M 3 □ Widowed 4 □ Divorc	arried	12. Wes Deceder Armed Forces 1 X Yes 2 If Yes, Give Yaer or Datas	30 1960	0 -	3. Was Decedent of If Yas, specify Cu 1 ☐ Yes 2 🛣 No		Specify Yes or N rto Rican, etc.)	10-	14. Race - Black, Specify:	Whita, e		
15-002 72 hours "netural",	eted	15. Deced (Specify only high	ent's Educ	cation completed)		16e. De	cedent's Usuel Occiva kind of work don a. DO NOT use retir	upation e during most of wo	orkina	16b.	Kind of Busi	ness/Ind	lustry	
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Baltimore, pemit. Pages 1 en Department of Heal important: If Item 2 any Inlury or other		20a. Method of Disposition			20b. Pla	aca of Di metery, o	sposition (Nama of crematory or other p	laca)	Date	20c. l	ocation - Ci	ity or To	wn, Stete	
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Physician	_			^									Onset end (
/Medica Examine	_	Immediate Ceuse (Finel disease or condition resulting in death)	е	He	UTE	П	EPATIC	, JAIL	ure				men	14
	6			High		es e con	sequence of):	Abuse				1	200	
uted	Examiner		p b	Hist	_		sequence of):	10026	•			-	20 Y R	<u> </u>
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O. E e dea	Physician	Pert II. Other significant condi	tions con	tributing to death	but not rasui	ting in th	a underlying cause (iven in Pert I.	23b. Die	d tobacc	o use contr	ibute to	the cause o	of death?
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		25. Was case referred to medi-	al.							77.4.7	2/00/10	1 .	Yes 2	No
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O & 5 8		27. Manner of Deeth	1	28e. Dete of In		28b. Time	e of 28c. Inj		28d. Describe				9	
VISION O Attending Ph ar death. ector: After thi by the funeral	atio	1 Naturel 5 Pend 2 Accidant inves	ling stigation	(Month, L	Day Year)	Injur		ork? ⊒Yes 2⊒No						
Division or Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	d not be mined	28e. Plece of i	njury - At honetc. (Specify)	ne, farm,	street, fectory, office	•	28f. Location City or To			or Rurai	I Route Num	ber,
urs al		J.												
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1/5 Certify (Check only one) 2 Medical	ring Physi si Examin	er: On the bes er: On the basis end menner:	of exemination	ledge, de on end/or	eeth occurred et the r Investigation, In my	time, date end plec opinion, deeth occ	a, end due to the urred at the time	e ceuse(e, date ar	s) end menr nd place, sn	ner es sto d due to	eted. the cause(s	i)
To t	Σ	29b. Signeture and titla of carti		-				nsa number		29d. D	ate signed (Day, Year)	
		1 Kama	o K	. Gal	ال أداد	m	D3	1660		1	114	98		
		30. Name end eddress of perso	n who cor			23a) (Typ			4	9 - 400-		- 12		
		31. Dete filed (Month, Day, Yes	K- (Alvin 32 Region			295 57	ONER	AVE (NEC	MIN	SIER	- WD 3	トルラ
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 2 3 5 2 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Rideout 1202 Milton Darnel January 17, 1995 /Medical 4c. County of Deeth 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs.
Hours Min.

8. Dete of Birth (Month, Dey, Yeer)
(Month, Dey, Yeer)
August 06, 1953 Mary 10 Nd 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year Birthplece (Stete or Foreign Country) 6. Sex **Funeral** 1 M 2 F 44 Yrs. Months Deys 214-66-7970 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23s or 28a-f show traumatic event, the Madical Examiner must be nothing at 1 X Yes 2 □ No Director Rhodesdale Maryland Dorchester 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? 4909-21659 Forest Road Funeral Maiden U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien Bleck, White, etc. 11. Maritel Status 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Completed by Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) 0 Never Employed Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Surname) Be Pages 1 and 2 should be 1 nent of Health end Mentel Thomas Hubert Ruth Rideout 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health end Important: if Item 27 is m any injury or other traum 21659 4909 Maiden Forest Road-Rhodesdale, MD. Rideout 20b. Place of Disposition (Name of cemetary, crametory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cramation 3 Removel from Stete 1/22/98 Rhodesdale, Maryland Reids Grove Cemetery
22. Nama and Address of Facility 4 ☐ Donetion 5 ☐ Other (Specify) Pent. Ear the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiretory errest,

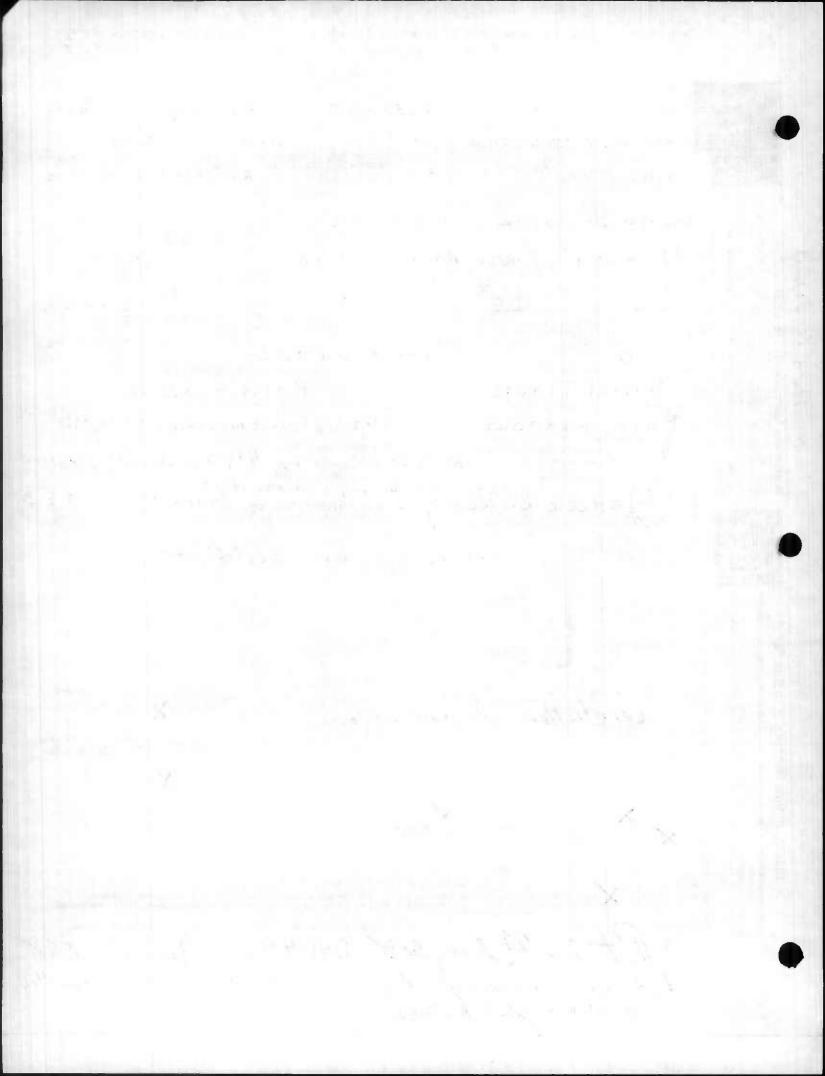
Approximata 21. Signeture of Funeral Service Licensee **Physician** accident /Medical Immediate Ceuse (Fine) (erebro vascu disease or condition resulting in daath) Examiner Due to (or es e consaquança of): Sequantially list conditions, if eny, leading to immediate cause. Enter Undarlying Ceusa (Disaasa or Injury that initieled evants resulting in daath) Lest Dua to (or as e consequence of) To the Hospital or Attending Physician: The law requires that the death certificete be exect within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurrial. P.O. Box 68760. Physician/Medical Due to (or es e consequence of): Pert II. Other eignificent conditions contributing to death bythot rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 0 3 Probably 4 ☐ Unknown 0 Records. à 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? Division of Vital 25. Was case rafarrad to medical exeminer? 28. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Daath 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 5 Panding 1 ☐ Yes 2 ☐ No 2 Accident invastigation 3 Suicide 6 Could not be 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledga, daath occurred at tha time, dete end piece, end dua to tha ceuse(s) end menner es steted.

Medical Examiner: On tha basis of examination end/or investigation, in my opinion, death occurred at the time, data and pieca, and dua to the cause(s) end menner stated. 29a, Cartifier 29b. Signature and the of certifier 29c. License number 29d. Dete signed (Month, Dey, Yaer) eddress of person who completed cause of daeth (Item £3e) (Type, Print) Tahone CIA 6 31. Date filed (Month, Day, Yeer) JAN 2 1 1998 State Daugher Kardall

DHMH 16 Rev 6/95

Registrar



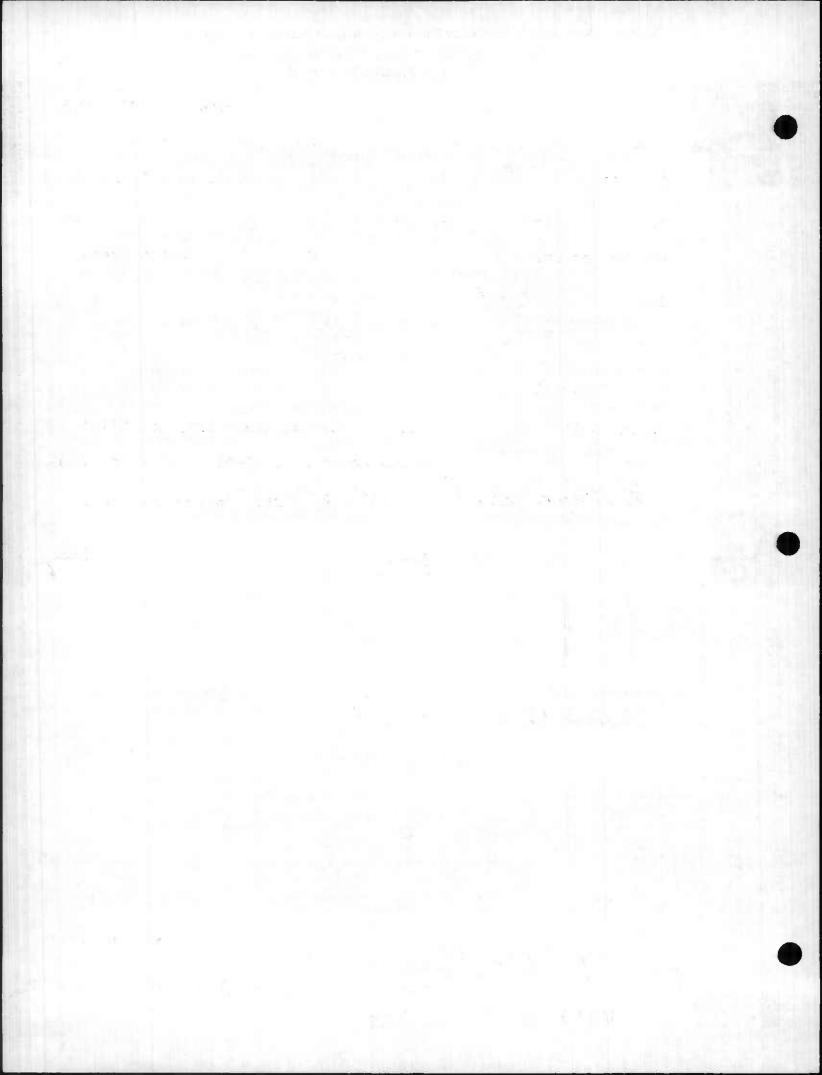
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					Ce	rtificate	of Death		Reg. No. 9	3 0	235	3
Physician		Decedent's Name (First, Middle, L						2. Date of De Month	eth Dev	Year	3. Time of	Death
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	4	St. Agnes Hos				If Under 1	Catonsv Year If Under 24 H			ltimo		
Funeral Director		5. Sociel Security Number 232–78–0867 Usual Residence of Decedent	Sex 7. Ag 1□ M 2√√ F	87	ast birthday) Yrs.		Days Hours Mi		1910	9. Birthp Cour W • V	place (State on htry) a	r Fore
2 A w	_	10a. State 10b. County		10c. City	, Town or Lo	ocation				1	0d. Inside Ci	tv Limi
28a-f sh office		W.Va Minera	al 	E	lk Gar			T			1 ☐ Yes	
or tems 23s or 28s-fs: Three must be notified Funeral Director		PO Box 14					5717		10g. Citizen of USA	What Cour	ntry?	
by by		11. Marital Status 1 □ Never Marrled 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Detes:				nt of Hispanic Origin? Cuban, Mexicen, Pue	Specify Yes or No rto Ricen, etc.)		ce - Americ eck, White, fy: Whi	etc.	
lygiene. The Medical in Completed		15. Decedent's l	Education rade completed)		16a. Dece	dent's Usual (Occupation	orkina	16b. Kind of 8	Business/In	dustry	
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J Men natic												_
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Heall am 2 other	2	Lenora Schwinaba	ILL	20b. PI				Date	20c. Location	• City or To	wn State	
tment of tant: If it jury or o		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	ity)			osition (Name matory or othe Cemet		Jan 15 9			n W.Va	
Deper Impor	1	21. Signature of Funeral Service Lice	Burdock		22		Address of Facility d A. Burdo	K: ck Funera	itzmille al Home	er,Md	21538	
ste has been signed by the ettending physician end page 2 should be deteched for use as the bunel-transit and page 2 should be deteched for use as the bunel-transit and page 2.		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	C	Due to (or	as a consequence as a c	quence of):	al int	arct	ción		yed	5
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nis ce		examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2/21	ER/Outpetien	nt 3 DOA	Other: 4 Nursing	Home 5 ☐ Resid	dence 6 □Oth	her (Specify	y)	
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		2 ☐ Accidant Investigation	on	, , , , ,	,,	М	1 ☐ Yes 2 ☐ No					
oath. he fui			28e. Place of Inj	ury - At hor	ma, farm, str	eet, factory, o	ffice	28f. Location (S	Street and Numi vn, State)	ber or Rura	l Routa Numi	oer,
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124 hours effer death. • Funeral Director: Aftert bletely filled in by the funeral cartification:	2	4 Homicide determined	hysician: To the best of minar: On the basis of and manner ste	of my know	viedga, daath ion and/or inv	n occurrad at vestigation, in	he time, date and place my opinion, daath occ	e, and due to tha	cause(s) and m date and place,	anner as st	lated. tha cause(s)	
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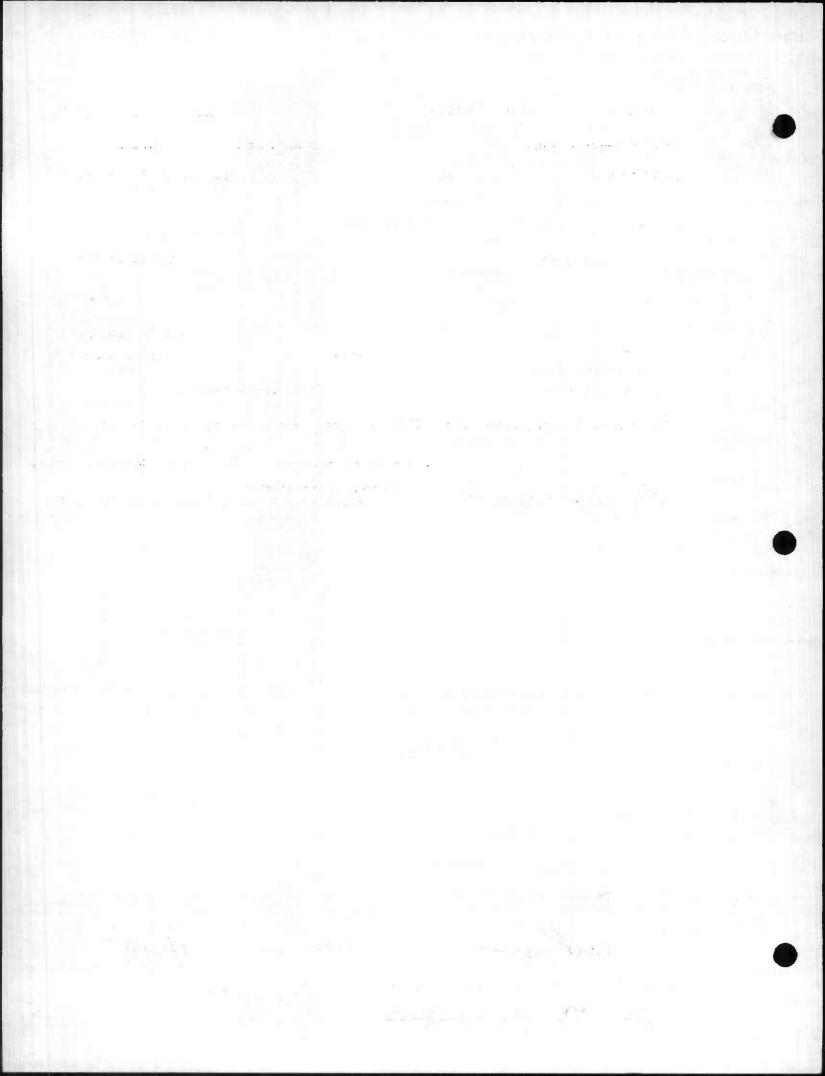
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/Medi		ANNA VIRGIN							JANUAR'		998	19:54
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	×	SACRED HEAR'			ring and Miller	der 1 Yaar		ERLA			EGAN	
Funeral Director		5. Social Sacurity Number 215-34-4833 Usuel Residence of Decedent	M 2□NF	(In yrs. last i	Yrs. Monti			Min.	Data of Birth (Month, Dey, DCt. 1	Year) 3 191	9. Birthp Cour 3 Ma	olece (State or F otry) ryland
show		10a. State 10b. County		10c. City, To	own or Location						1	0d. Insida City I
두필	Į.	Md. Allega	anv	West	ternpor	-+						1 Yes 2
288	rec	10e. Street and Number	1			Zip Code			10	og. Citizen of \	Whet Cour	ntry?
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"naturel", or items 23e or 28a-f show poical Examiner must be notified at	by Funeral Director	11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Yaar or Dates:				Hispenic Ori an, Mexican	gin? (Specii n, Puerto Ric	y Yes or No- an, etc.)	14. Rac	ce - Americ ck, White,	an indian,
a di	P	15. Decedent's Ed	lucetion	16	Sa. Decedent's U	suel Occur	petion		1	6b. Kind of B	usiness/Inc	dustry
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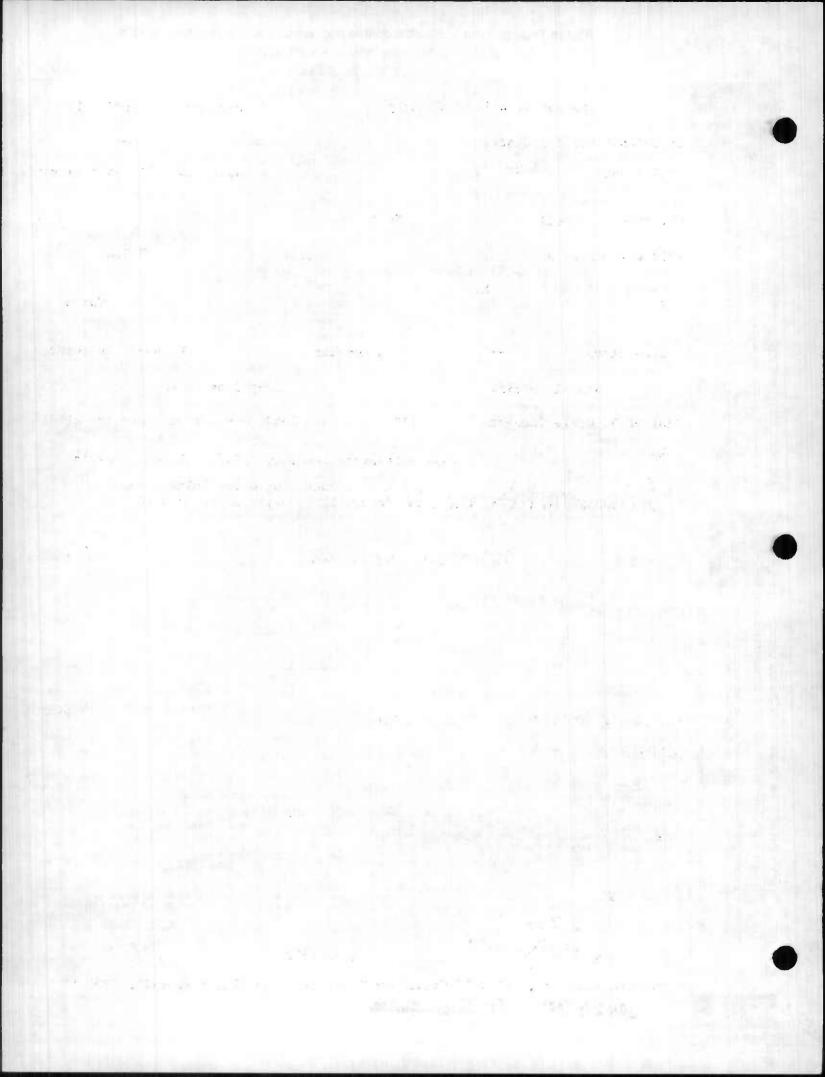
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Page 109 8

					Cer	tificate of	Death		Reg. No.	Ud	2336
		1. Decedent's Neme (First, Middle	, Last)	3177				2. Dete of De	eth Dey	Yeer	3. Time of Deeth
	Physician /Medical	Вец	lah B. He	lmick St	uckey			Januar		1998	11:10 pm
	Examiner	4a Fecility Neme (If not institution	, give street end num	iber)			4b. City, Town, o	r Location of Deet	h 4c. County	of Death	
		Laurelwood Nurs	ing Cente	r			Elkto			Ceci	
	Funeral Director	5. Social Security Number 236-14-5609	6. Sex 1 □ M 2√XF	7. Age (In yrs. les 86	t birthday) Yrs.	Months Deys		8. Dete of Bir (Month, De March	15,1911	9. Birthpi Count We s	lece (Stete or Foreign try) t Virginia
p		Usual Residence of Decedent		140 00							
Z	d at	10a. State 10b. County		10c. City,	Town or Loc					10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
×	oto	Maryland Ce	cil		No	rth Eas	t				**
ŧ.	or 2 be ns	10e. Street end Number				10f. Zip Code	0.1001		10g. Citizen of		
ath w	23a	2712 North East					21901			.S.A.	
21215-0020 d within 72 hours after death with the Mandand	end Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show sumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	Armed For	XXNo		Vas Decedent of Yes, specify Cu ☐ Yes XX No	Hispenic Ongin? (ben, Mexicen, Pue	Specify Yes or No into Ricen, etc.)	Specif	e - America ck, White, o	
5-0	ygiene. Ner than "nature It, the Medical I	15. Deceden	s Education		16e. Deced	ent's Usuel Occu	upation a during most of w	odina	16b. Kind of B	usiness/Inc	dustry
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any shot	uma uma	19e. Informent's Neme/Reletions	nip (Type, Print)		19b. Mailin	g Address (Stree	et end Number or i	Rurel Route Numb	er, City or Town	Stete, Zip	Code)
2 0	Health em 27 is	Pauline V. Coal	e (daught	er)	2712	North E.	ast Road	, North I	East, Ma	rylar	nd 21901
O -	Department of Heelth important: If item 27 any injury or other to ance.	20e. Method of Disposition		cerr	oe of Dispos	sition (Neme of netory or other pl	acel	Dete	20c. Location	City or To	wn, Stete
mor Peges	ont: H	1 XX uriel 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (S					Cemetery	1/19/98	Colora	. Mar	yland
Balti Permit.	Depertment Important: If any injury of the price.	21. Signafure of Funerel Service			22	Name and Add	ress of Fecility				
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1	nysician Medical xaminer	23a. Pert1. Enter the disease, or shock, or heart failure. List Immediate Cause (Finel disease or condition		used the deeth.	Do not ente	er the mode of dy	ring, such es cardi	ec or respiretory e	orrest,		Approximate Interval Between Onset and Death
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ecords, P.O. Box 68760, lew requires that the death certificate be executed	ding physicle se es the bu Medical	resulting in death) Lest	d	Due to (or e	s e consequ	uence of):					
Box ath cert	attendin for use										
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T 9	- 5 5							10	Yes 21 No	10	Yes 2□ No
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of Vital	To B		Hospital:	patient 2 EF	R/Outpetien	1 3 DOA C		Home 5 ☐ Res		ner (Specif	y)
	within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be (28e. Dete o		8b. Time of Injury	28c. Inj W			how injury occu		
5 8	al Director: After I ed in by the funer: Certification:	3 Suicide 6 Could determ	ned 286. Piece	of Injury - At hom g, etc. (Specify)	e, farm, stre	et, factory, office	9	28f. Location (City or To	(Street end Numi wn, Stete)	ber or Rure	el Route Number,
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

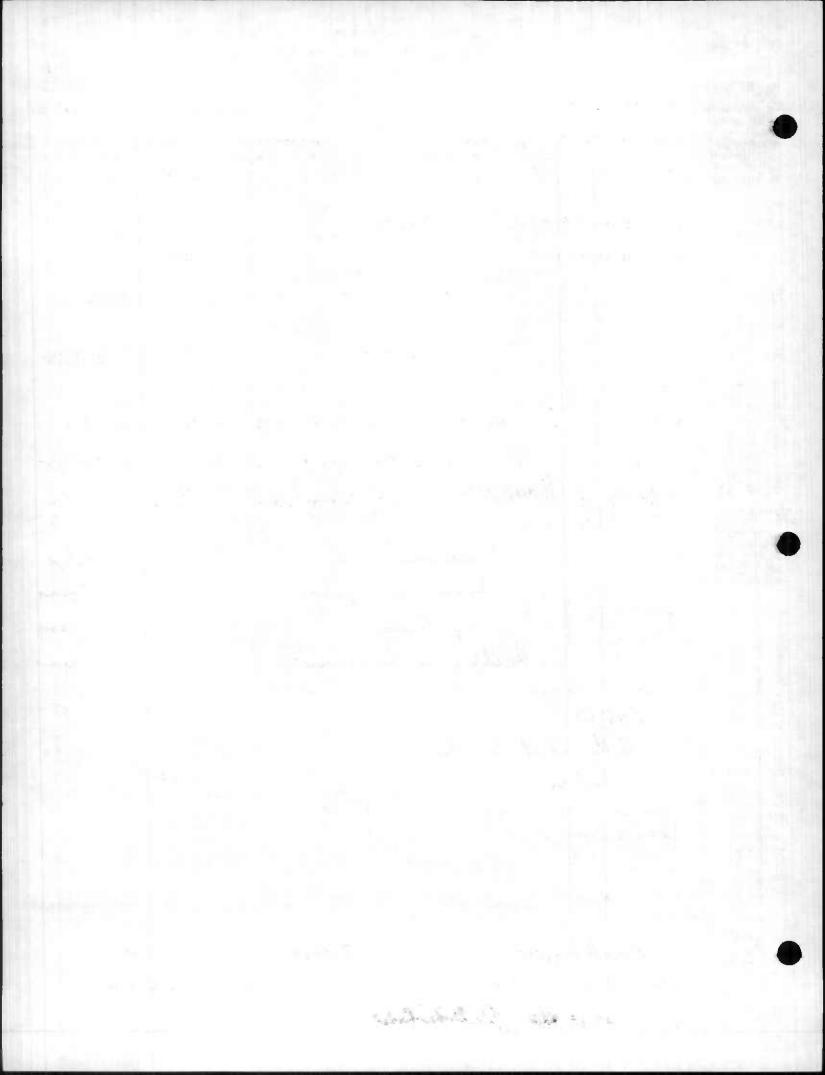
Certificate of Death

Per No. 98

02357

					Certificat	e of	Death		Re	g. No.	j U	6351	
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Physicia /Medic		Donald W. Swain								ry 14, 1998		10:47 a	
Exami		4a. Facility Nama (If not institution, give	ra straat and number)				4b. City, Tow	n, or Location	on of Death	4c. County	of Death		
		Anne Arundel Me					Annap			Anne	Arund	de1	
Funeral Director	Director	5. Social Sacurity Number 6. S 015-22-8106 Usual Rasidence of Dacedant	MM 2DE	In yrs. last birtl	frs. if Under Months	1 Year Days		Min.	Data of Birth (Month, Day, b. 15,			laca (Stata or For try) sachusett	
within 72 hours efter death with the Meryland ene. Then 'neturel', or items 23a or 28a-f show the Medical Examiner must be muttled at		10a. State 10b. County		Oc. City, Town	or Location gewater						10	0d. Insida City Lin	
		Maryland Anne Ar	ander	Lug	10f. Zip	Coda			10	g. Citizen of V	What Coun	trv?	
		144 Washington R	oad		2	103	7			J.S.A.			
d within 72 hours efter des giene. r than "natural", or items the Medical Examination	by Funeral	11. Marital Status 1 ☐ Navar Marriad 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forcas? 1 X Yes 2 No If Yas, Giva	1 X Yes 2 No 1946-		13. Was Dacedant of H If Yes, specify Cube 1 ☐ Yas 2 ☑ No		Hispanic Origin? (Specify Yas or Noben, Mexican, Puarto Rican, atc.) Spacify:		No- 14. Raca - Ame Black, Whit Specify: W		etc.	
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nd 2 s alth en 27 ls p					Mailing Addrass								
Heel Heel		Marsha S. Thompso: 20a. Mathod of Disposition			95 White Disposition (Nam		ral Co			Mary J			
permit. Pages 1 end Department of Heelt Important: If item 27 any injury or other tonce.		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specif	Ramoval from State	camatar)	olitan (thar pla					•	Wirginia	
Depending Depending Important In any In 2000		21. Signeture of Funaral Service Licentee 22. Nama and Address of Facility Francis Gasch's Sons Funeral Home, P.A.											
Dhusisian	Examiner	23a. Pad 1. Entar the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory errast, shock, or heart failure. List only one cause on each line. 4739 Baltimore Avenue, Hyattsville, MD 20781 Approximate Interval Batween Onset end Deeth											
Physician /Medical Examiner		Immadiata Cause (Final disaasa or condition resulting in death) e. Prilumpuin								3 days			
10.00			C Du	e to (or as a c	onsequance of):	1	2				ļ		
nsit ited			b. Mus	mie ,	rend,	for	lure				i	> year	
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ew requir		Multi mj	but deme	tu					24a. Was en parform	autopsy ed?	ava	ora autopsy finding silable prior to npletion of cause deeth?	
The page		Laterta							1 🗆 Yas	2 12 NO	1□	Yes 2□ No	
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\$ 00		axaminary Hospital Other							5 Rasidan	ica 6 □Oth	ar (Specify	1)	
Hospital or Attending 4 hours efter deeth. Funeral Director: After tely filled in by the fune		27. Manner of Deeth 1 Natural 5 Panding 2 Accidant invastigation		Be. Data of Injury (Month, Day Year) 28b. Tima of Unjury et Work? M 1 ☐ Yas 2 ☐ No					Describe how	ibe how injury occurred			
		3 Suicida 6 Could not be datarmined 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number City or Town, State)								er or Rural	Routa Number,		
		29a. Certifiar (Check only one) 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner stated.									ated. tha causa(s)		
within 2 To the		29b. Signature agd titla of certifier						29d. Data signed (Month, Day, Yea			Day, Year)		
7		b 6 1/11 1-				0-	cic =			1/14/98			
(5)		30. Name and addrass of person who	complated causa of daat	h (Itam 23a) /7			5499						
()		11 0 . 1	4.4			^	Dr	1		wn	31110	1	
01	•	31. Data filed (Month, Day, Year)	180 Avenu		Cochran	6	ur	mna	polls	MI	2140	L	
Sta Registi	-	IAN 18 T			Part H								

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 12 1/11 1. Decedant's Nama (First, Middle, Last) 2. Data of Death **Physician** JANUARY 13 1998 HARRY L. SANDERS 6:30pm /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5531 Sheriff Road Capitol Heights Prince Georges | Months | Deys | Hours | Min. | APRIL 3, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (Stata or Foraign Country) **Funeral** 1₽M 2□F Yrs Director 58 1939 SOUTH CAROLINA 578-52-2483 Usual Rasidance of Decedant with the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ral', or items 23s or 28s-f show Examiner must be notified at Director 1 ¥Yas 2 No MARYLAND PRINCE GEORGES CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 5531 Sheriff Road 20743 United States deeth Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Maritel Status should be filed within 72 hours after of Mental Hygiene.

marked other than "natural", or ite 1 ☐ Yes 2 🔯 No If Yas, Giva Yaar or Datas: 1 □ Naver Married 2 □ Marriad Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify þ Specify: Black 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) 12 PRESSMAN PRIVATE/GOVERNMENT 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Surname) Peges 1 end 2 should be 1 nent of Haelth end Mental 1 JUDSON SANDERS HESS SELLAR RICE 19e. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Steta, Zip Code) permit. Peges 1 end 2 s Depertment of Haelth er Important: if item 27 is any injury or other trau APRIL KIMBERLY SANDERS/DAUGHTER 5531 Sheriff Road, Capitol Heights, Md. 20743 20b. Place of Disposition (Nema of cematary, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 1/17/98 Landover, Maryland 22. Name and Addrass of Facility ALEXANDER S. POPE FUNERAL HOMES M859 5538 Marlboro PIke, Forestville, Md. 20747 23a. Part1. Enter the disease, or complications that usused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Examiner The law requires that the death certificete be axecuted Sequantially list conditions, if any, leading to Immediata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants resulting in death) Last Due to (or es e consequance of) physician s the burial P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): signed by the at d be datached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2500 3 Probably 4 ☐ Unknown Records, þ Be Completed 24b. Were eutopsy findings evailable prior to 24a. Was an autopsy complation of cause of deeth? page 2 2 XN0 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 24 hours efter death. director, 25. Was case referred to medical 26. Place of Death (Check only one) 2 1□Yes 25 No Other: 4 Nursing Home 5 (AResidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mannar of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accidant 5 Panding Investigation 1 Yes 2 No Director: / 3 Suicida 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Numbar or Rural Routa Number, City or Town, Stata) in by 4 Homicide • Funeral Medical Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner es steted.

Medical Exeminar: On the basis of axemination and/or invastigetion, in my opinion, death occurred at the time, date end place, end dua to the ceuse(s) and mannar stated. 29a, Certifian

penpletely vithin 2 To the

State Registrar 29b. Signature and title of certifier

D

JAWES .

31. Data filed (Month, Day, Year) 32. Registrer's Signatura

2150

17

30. Name and eddrass of person who completed cause of death (Itam 23a) (Type, Print)

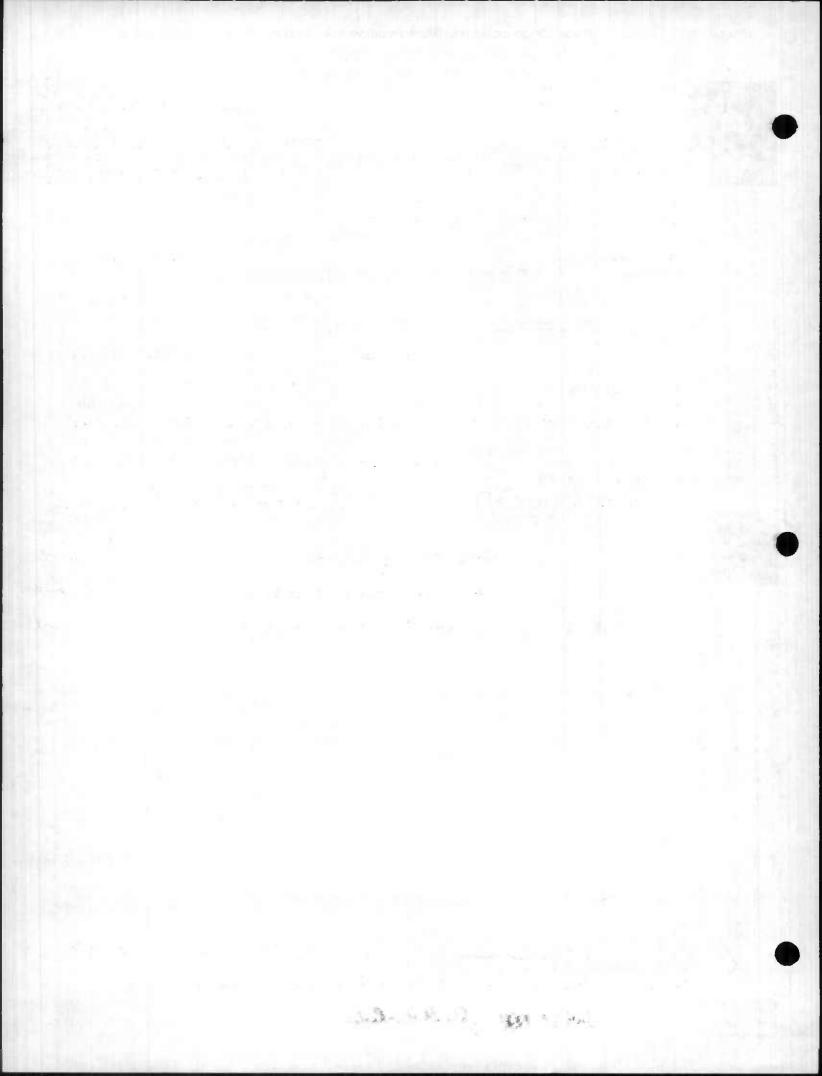
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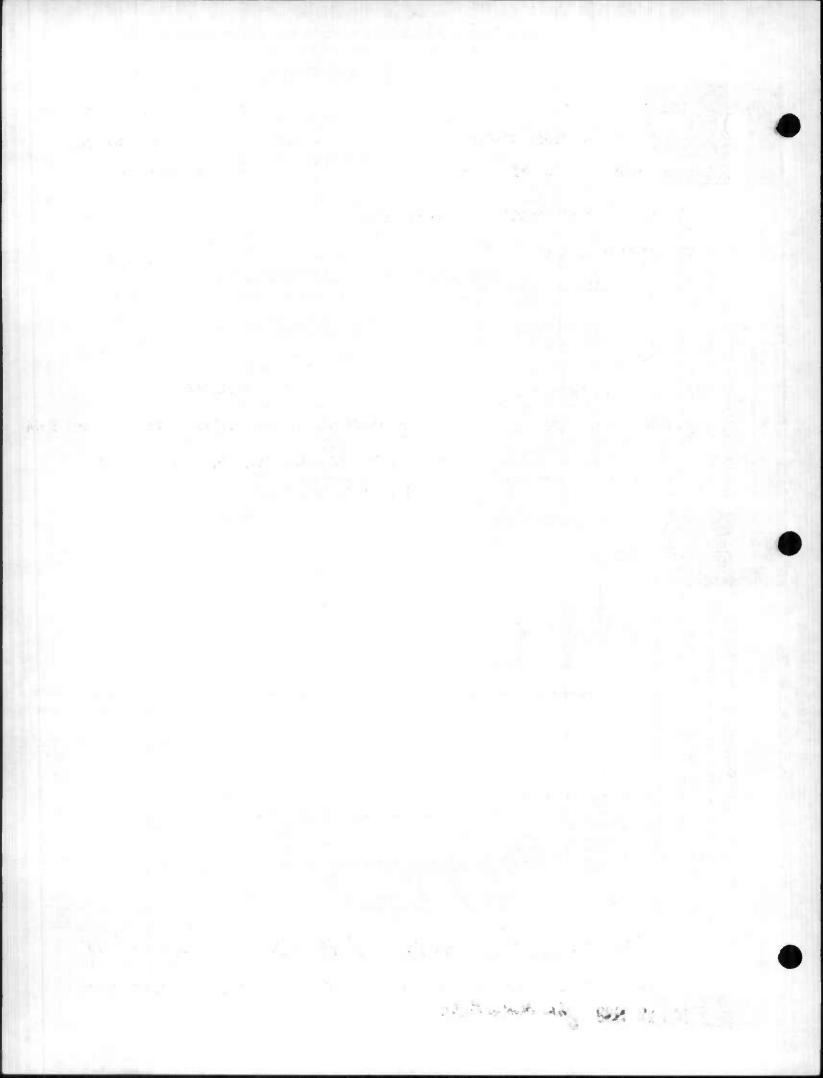
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29d. Data signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Q

				C	ertificate	of Death		Reg. No.	02335	7		
Physic	an	Decedent's Name (First, Middle, Last)				2. Dete of De Month	eath Day	3. Time of D	Death		
/Medi		LEE L. SNOW JR.						05, 1998		AM		
Exami		4e. Fecility Neme (If not institution, give				4b. City, Town, o	or Location of Deat	h 4c. County	of Death			
		SOUTHERN MARYL	AND HOSPITAI	_		CLINTO		PRINC	E GEORGES			
Funeral Director		5. Social Security Number 6. Se 416-60-8096	ear If Under 24 H eys Hours M	in. (Month, Di								
pu »	Director	Usual Residence of Decedent	10-	Oh. Tour	1 1							
aryla ehov		10e. State 10b. County 10c. City, Town or Location FORESTVILLE							10d. Inside City			
M Page			3EUNGES	LOKES	IATPE				XXXYes 2	Z 🔲 NO		
9 4 5 E	100	10e. Street end Number			10f. Zip Co	de		10g. Citizen of W	/het Country?			
23a	T T	6589 PENNSYLVANIA	AVE.		2	0746		UNITED	STATES			
ep	To Be Completed by Funeral	11. Meritel Stetus	12. Was Decedent Ever I Armed Forces?	ed Forces? If Yes, specify Cuban, Mexica			c Origin? (Specify Yes or No- xican, Puerto Rican, etc.)		14. Rece - American Indian, Black, White, etc.			
within 72 hours effer deeth with the Maryland liene. Than "natural", or hems 23a or 28a-1 show The Medical Examinat must be inclified at		1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			No Specify:			: BLACK			
72 hc		15. Decedent's Edu (Specify only highest grad	cation	16a. De	cedent's Usual O	ccupation	undking	16b. Kind of Bu	siness/Industry			
within then then		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+)										
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d 2 should be filed th end Mental Hygis 7 Is marked other traumatic event, 1		17. Fether's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle	Malden Sumame)				
should be ind Mental marked o		LEE L. SNOW. SR. EMMA						WILLIAMS				
sho sho		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. M	alling Address (St	reet end Number or	Rural Route Numb	ural Route Number, City of Town, State, Zip Code)				
t and 2 Health em 27 I		DENISE SNOW/ WIFE	3	658	89 PENNS	YLVANIA A	VE. FORI	ESTVILLE	, MARYLAND	207		
		20e. Method of Disposition	20	b. Place of Dis	sposition (Name or cremetory or other	of place)	Date	20c. Location -	City or Town, Stete	And Selection		
Day To D		1 Burial 2 □ Cremation 3 □ F 4 □ Donation					TAN 10	1000 TAB	NDOVER, MD			
교원관등 .		21. Signature of uners Service Licens		-00	22. Name and A		QAIV. 10,	1990 LAI	IDOVEK, MD			
Depa Impo		* Tollears	11/11/10	les	DUDLEY F	UNERAL HOL	ME					
_		EDW	ARD M. DUDL	EY !	3200 RHO	DE TSLAND	AVE. MT	C. RAINIE	ER, MD 207	12		
		23a. Part1. Enter the diseese, or compleshock, or heart fallure. List only or	ications that caused the c ne cause <i>on</i> each line.	teeth. Do not	enter the mode of	dying, such as card	liac or respiratory e	errest,	Approximate Interval Between	een		
Physician	Examiner	CONTRACTOR AND PROPERTY.		Onset and Deet			∌eth					
/Medical Examiner		Immediate Cause (Final disease or condition RESPIRATORY FAILURE							8 DAYS	S		
Examiner		Due to (or as a consequence of):										
D #			VOCAL	CORD PA	ARALYSIS				2 MONT	PHT		
than than		Sequentially list conditions,	Due t	o (or as a con	sequence of):					LILL		
0 0 mm	E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	NASOPH.	ARYNAEA	AL CANCE	?		15 MON	NTH:			
ficate be execut g physician and as the butlat-tran	edical	Cause (Desease or injury that initiated events resulting in death) Last Due to (or es e consequence of):										
- O - W	-											
eath cert attendin	Pa V		d	,					1			
death e atter ed for u	Sich	Part tt. Other significant conditions cor	ntributing to death but not	resulting in the	e underlylng caus	e given in Part I.	23b. Did	23b. Did tobacco use contribute to the cause of death?				
that the de led by the a deteched i	Physician/N						10	1 ☐ Yes 📆 No 3 ☐ Probably 4 ☐ Unknown				
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requires ween sign hould be	Be Completed						24a. Was	en autopsy ormed?	24b. Were autopsy fine available prior to	_		
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certificate rector, pag		25. Was case referred to medical				26. Plece of D	Death (Check only	one)				
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To the Hospital or Attending Phy Within 24 hours effer death. To the Funeral Director: Affer thi completely filled in by the funeral		29e. Certifler (Check only Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) and manner es stated.										
thin 2, the F	Ped	one)	and manner stated.									
P P	M	29b. Signature and title of certifier 29c. License number 29d. Date signed (A										
(5)		Subar M.D. 143772							8/ 48			
		30. Name and address of person who co	empleted cause of death (Item 23a) (Typ	e, Print)							
		RASAD ABU M.D				TE 208B,	CLINTON	MARVIAN	D 20735			
Sta	te	31. Date filed (Month, Day, Year)	32, Registraris Si	ignature			OTTIVION &	TIGHTLEAN	401.33			
Registr		JAN 12 1998 Jul	w obwedges hero	64								



State of Maryland / Department of Health and Mental Hygiene

			- Otate of Maryla		tificate of			Reg. No. 98	02360		
Physici /Medic		Decedent's Neme (First, Middle, Las	Jessie	Mae	Sumter		2. Dete of De- Month 01	Dey	yeer 98 9:30 PM		
Examir		4a. Fecility Name (If not institution, give Golden Oaks Co	A PARTIE TO THE	Reha		4b. City, Town, or L Laure	ocation of Deeth	4c. County			
Funeral Director		Social Security Number 6. Security Number			If Under 1 Year Months Deys	ff Under 24 Hrs.	8. Date of Birt (Month, De 11-2		9. Birthpleca (State or Foreign Country) South Carolina		
Merylend H show	tor	Usuel Residence of Decedent 10a. State 10b. County Maryland Prince	George's	ity, Town or Loc		pitol Hei			10d. Inside City Limits 12☑ Yes 2 ☐ No		
th with the 23a or 28s	Funeral Director	10e. Street end Number 810 Cedar Hei	ghts Drive		10f. Zip Code	20743		10g. Citizen of W	/hat Country? USA		
5-0020 72 hours after deeth with the Meryland natural; or items 23s or 28s4 show pical Examiner must be notified at	þ	11. Maritel Status XXX Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever In L Armed Forces? 1 Tyes 2000 No If Yes, Give Year or Dates:		Vas Decedent of I Yes, specify Cub ☐ Yes 2 ☐ No	Hispenic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	- 14. Race Black Specify:	- American Indien, k, White, etc. Black		
Baltimore, Maryland 21215-0020 permit. Peges 1 end 2 should be filed within 72 hours af Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or any injury or other traumatic event, in Medical Exercipance.	Completed	15. Decedant's Ed (Specify only highest gred Elamantary/Secondary (0-12) 6th	ucetion de completed) Collaga (1-4or 5+)	16e. Decede (Give k lifa. D	ant's Usual Occup kind of work done O NOT use retire	petion during most of work d)	king	16b. Kind of Bu	siness/Industry		
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Maryland d2 should be flie th and Mentel Hy 7 Is marked oth traumatic event	To	Herbert Sumter					Waver Grayton or Rural Route Number, City or Town, State, Zip Code)				
, Ma end 2 s saith ar 127 la		Jay Bee Sumter/S	on	6617	Stockton	n Lane, H	e, Hyattsville MD 20784				
Baltimore Pemit. Pages 1 of Department of He moortant: If Item inty Injury or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Jennovei Ironi Stete	_	sition (Neme of atory or other ple National		Date /14/98		City or Town, State Maryland		
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ds, P.O.	by Ph							1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown			
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of Vital I	To Be	25. Was cese refarred to medicel exeminer? 1 ☐ Yes 2 ☑ No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA Oth	26. Pleca of Deal			s (Chaoite)		
Division of Vita To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director,		27. Menner of Death 1 SNatural 5 Panding 2 Accidant Investigation	28e. Date of injury (Month, Dey Year)	28b. Time of Injury	Time of 28c. Injury et injury Work?		A Nursing Homa 5 Residence et 7 28d. Describe how inju es 2 No				
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Hospi 24 hou Funer etely fill	edicai	29a. Certifier (Check only one) Certifying Phy	sician: To the best of my kno ner: On the basis of exemine end menner stated.	wiedge, deeth ation end/or inve	occurred at the tirestlgation, in my c	me, date end plece, opinion, daath occur	end dua to the dred et the tima, d	cause(s) and mer deta end place, a	nner as stated. nd dua to the ceuse(s)		
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Sta Registra		31. Dete filed (Month, Dey, Yeer)	32. Registrar's Signe					- 1			

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

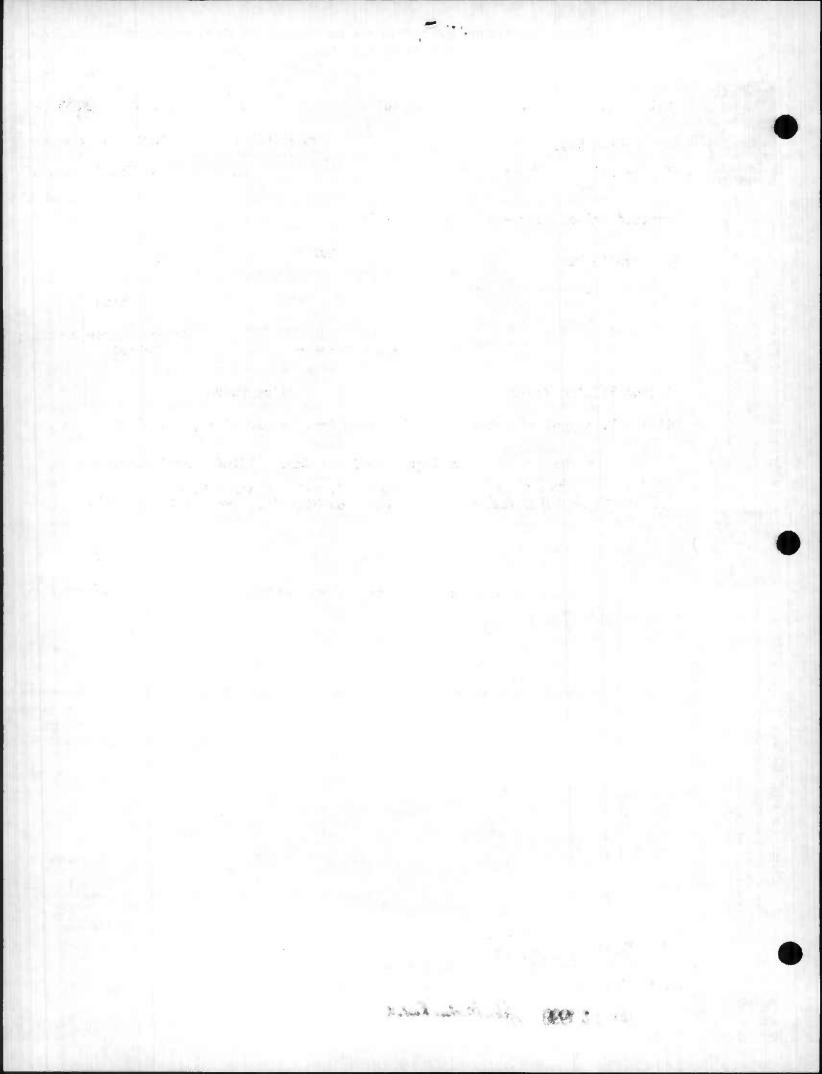
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ner	4e. Fecility Neme (If not institution, gir	ve street end number,)		4b. City, Town, or	Location of Deeth	4c. County	of Deeth
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	Usuel Residence of Decedent	Λ	04 113.			Jule 22,	1913	wasnington, L
	10a. Stete 10b. County		10c. City, Town or	Location				10d. Inside City I
to	Maryland Prince Ge	arges	Bowie	2				1 Ves 2
Director	10e. Street end Number			10f. Zip Code			I Og. Citizen of \	Whet Country?
	3412 Marlock Lane			2	0715		U	SA.
Funeral	11. Maritel Stetus	12. Was Decedent Armed Forces	Ever in U,S. 1	Wes Decedent of If Yes, specify Cul	Hispenic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Rac	e - Americen Indien, ck, Whita, atc.
by Fu	Never Married 2 Married	If Yes, Give Tyeer or Detes:	No	1□ Yes 2☒ No				"Caucasian
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o Be	James Swain				Mabel	Flood		
-	19e. Informent's Neme/Relationship			ailing Addrass (Straa				Stete, Zip Code)
	Ralph E. McGinnis (Grandson)	341	2 Marlock L	ane Bowie	Maryland	20715	
100	20e. Method of Disposition	70	cometen/ c	sposition (Neme of cremetory or other plant	ece)	Date	20c. Location -	City or Town, Stete
1	4 □ Donetion 5 □ Other (Speci			Veterans Ce		1/13/98	Chelten	nam, Maryland
	21. Signature of Edneral Service Lice	nsee		22. Name end Addr	ess of Fecility	Home		
	19 Usand	Tend		A CHARLEST CO.	polis Rd. I		nc Fractive	706
/Medical Examiner	Sequentielly list conditions, if eny, leeding to immadiate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events rasulting in death) Lest	c. Acu	Due to (or es e cons	TUCA	WIAL	INR	ARET	700 10 I
Physician	Pert II. Other significent conditions of	contributing to death b	out not resulting in the	e underlying ceuse g	iven in Pert I.			ntributa to the cause of
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Certification:	2 ☐ Accident investigation	n			Yes 2□No			
E	3 Suicide 6 Could not be datarmined	200. FIGUR OF ITE	jury - At home, farm, tc. (Specify)	street, factory, office		28f. Location (S City or Tow		per or Rurel Route Number
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Medical Cert	29a. Certifier (Check only one) 29 Medical Example of certifier	miner: On the basis o end mannar st	teted.		se number		29d. Dete signe	d (Month, Dey, Year)
edical	one) 2 Medical Exam	miner: On the basis o	Hendus	29c. Licen			29d. Dete signe	
edical	29b. Signature and title of certifier	end manner st	Hen Ly	29c. Licen	44436		29d. Dete signe	
edical	290. Signature and title of certifier 30. Name endladdress of person who	end mannar st	Hen Lyr deeth (Item 23a) (Typ	29c. Licen D-	44436		TAN.	
edical	29b. Signature and title of certifier	end manner st completed ceuse of ceuse of	Hen Ly	29c. Licen D- De, Print) Rd suite 2	44436		29d. Dete signe	

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth January 8, 1998 **Physician** Elizabeth A. Seganish 8:00 AM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Temple Hills Prince George's 3503 Leslie Ave. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | Min. | July 28, 1923 9. Birthplace (State or Foreign Country)
Washington, D.C 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 579-24-4855 74 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show 7 is marked other then "naturel", or items 23s or 28a-f shov traumstic event, the Medical Examiner must be notified at Yes 2 No Maryland Prince George's Director Temple Hills 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20748 238 3503 Leslie Ave. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Marital Stetus 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☐ No
If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 "naturel", or 1 ☐ Yes 2 ☐ No Specify White à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "n any injury or other traumatic event, the Heal once. Prince George's County College (1-4or 5+) Elementary/Secondary (0-12) School Teacher Schools 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be 2 August William Noack Alice Hudson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3503 Leslie Ave. Temple Hills, Md. 20748 William E. Seganish/Husband 20b. Piece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Arlington National Cem. 1/16/98 Arlington, Va. 22. Name end Address of Fecility George P. Kalas Funeral Home 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. P.rt1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or her feilure. List only one cause on each line. **Physician** /Medicai Immediate Ceuse (Finel disease or condition resulting in death) Bullous **Examiner** Examiner iclan and buriel-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest physician the buriel Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 98 esn. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? page 2 1 ☐ Yes 2 Ø No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending Investigation 1 Naturel e Hospital or Attendin n 24 hours after death. le Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 15 Certifying Phyelcian: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end manner es steted.

2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completaly fi (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) DO 1348 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) R.M. NEDZBALA, MP- 11761 LIVINGSTEN Rd. ET. WASH Md. 20144 32 Registrar's Signeture 31. Date filed (Month, Day, Year) State Registrar JAN 13 195



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** JAN EHU nms /Medical 4e. Fecility Name, (If not institution, give street and number) 4b. City, Town, or Logation of Death Examiner nen If Under 1 Months 00 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Year 1919 STAUNTON, VA. 78 577-22-4375 Director Usual Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Items 23s or 28s4 show other traumetic event, the Medical Example, must be notified at 1 Yes 2 □ No Director MARYLAND PRINCE GEORGE'S BRANDYWINE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with UNITED STATES 7811 KNOLLWOOD ST. 20613 Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 0 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mental Hygiene. Important: If flam 27 is marked other than "natural", or flen any injury or other traumatic avant. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No ρ Specify: BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HOMEMAKER PRIVATE 6TH 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **CLARA** DAVIS G. J. BRADY 2 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2602 FORT DR. SUITLAND, MARYLAND 20746 LORRAINE E. NEAL/ DAUGHTER 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 1/21/98 ARLINGTON, VA. ARLINGTON NATIONAL CEM. 21. Signature of Funerel Service Licensee ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE/FORESTVILLE, MARYLAND 20747 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Finel disease or condition resulting In deeth) /Medicai 2 Lours Examiner buriel-trensit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last end physician e Box 68760. that the death certificate be Physician/Medical ettending 1550 Islase USB 50 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contributa to the cause of deeth? the signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Was en eutopsy Completed Deen Wil 1 Yes 2 No 1 Tyes 2 No. Be 25. Was cese referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA funeral il or Attanding Pi s effer death. I Director: After th 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1 Netural 5 Pending Investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide To the Hospital or within 24 hours eft.

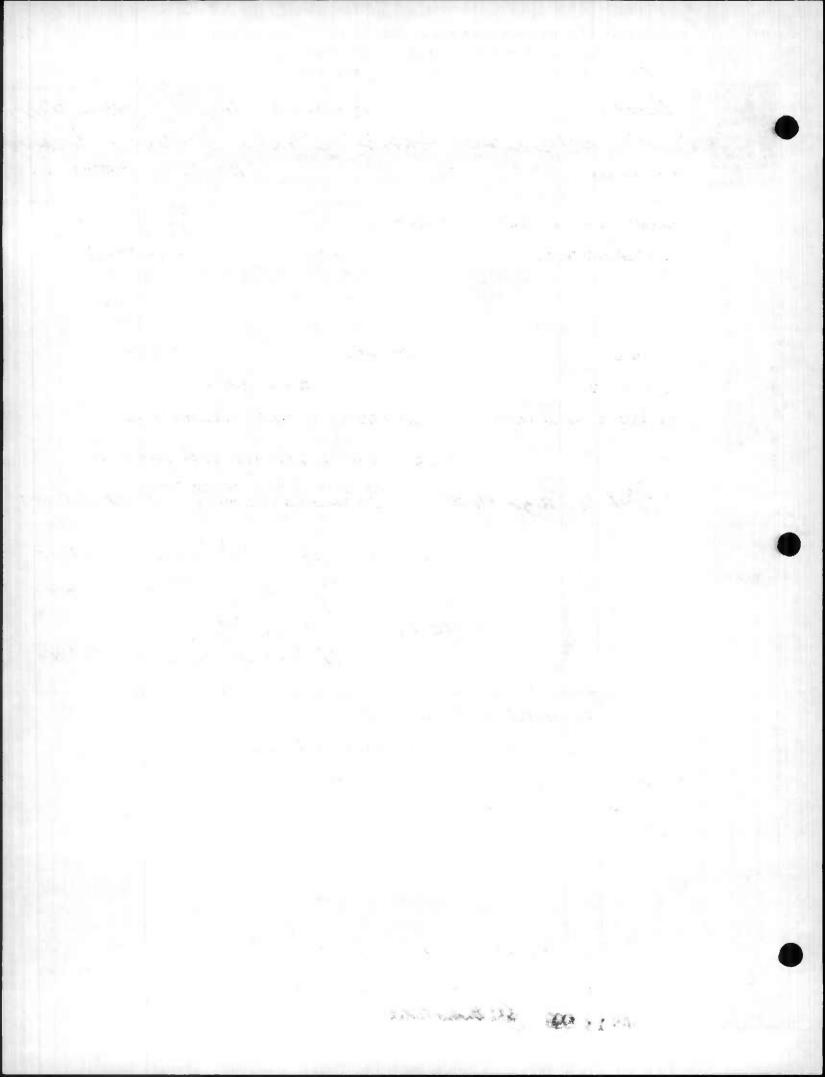
To the Funeral Dir completely filled in 1 Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) end menner es steted.

2 Medicel Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) 29c. License number who completed cause of death (Item 23a) (Type, Print) 20744 12825 Old Fort RJ Ff Wash Mi

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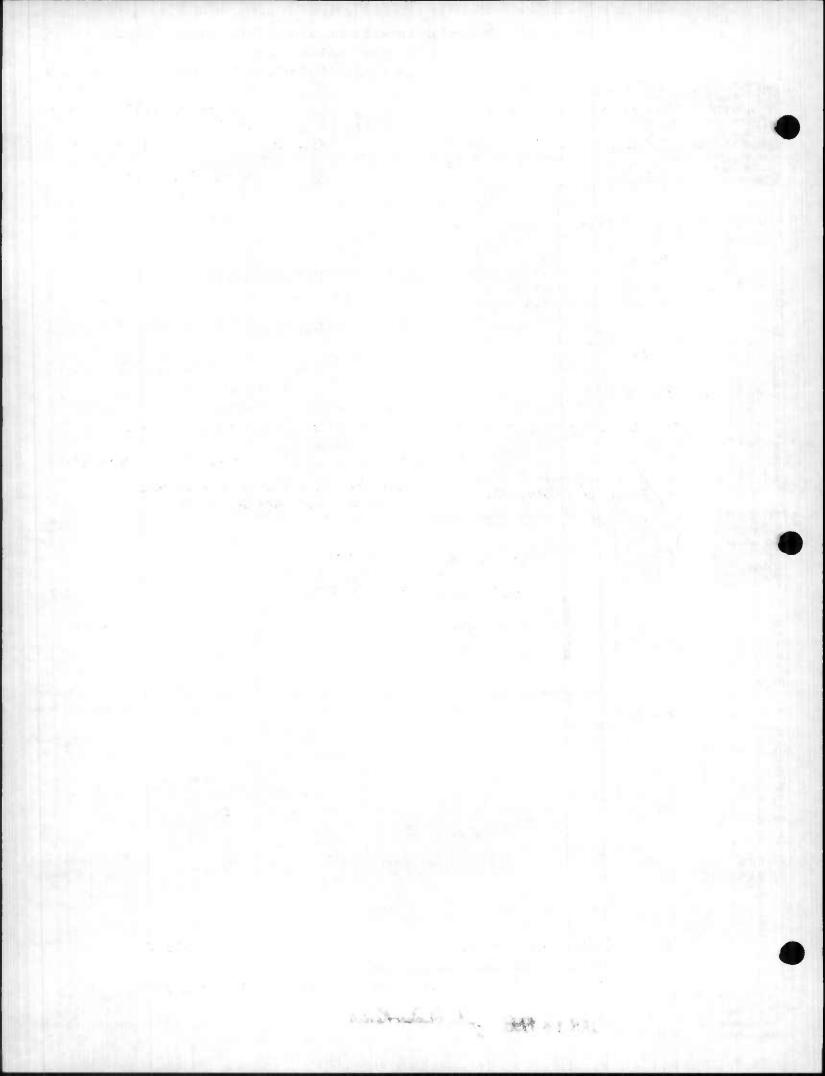
Registrar

31. Date filed (Month, Day, Year)



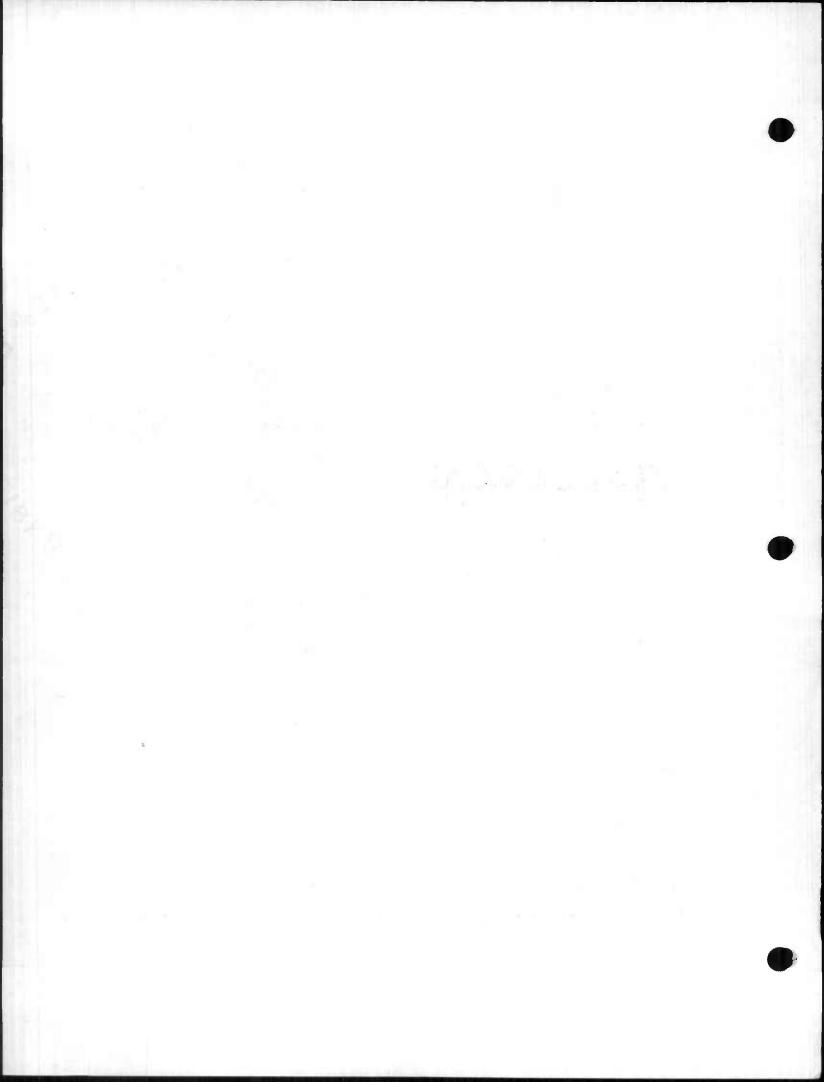
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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item 27 i	-	Bernita Y. Parke 20a. Method of Disposition		. Plece of Disposit		Road, Gr	Date	20c. Location		
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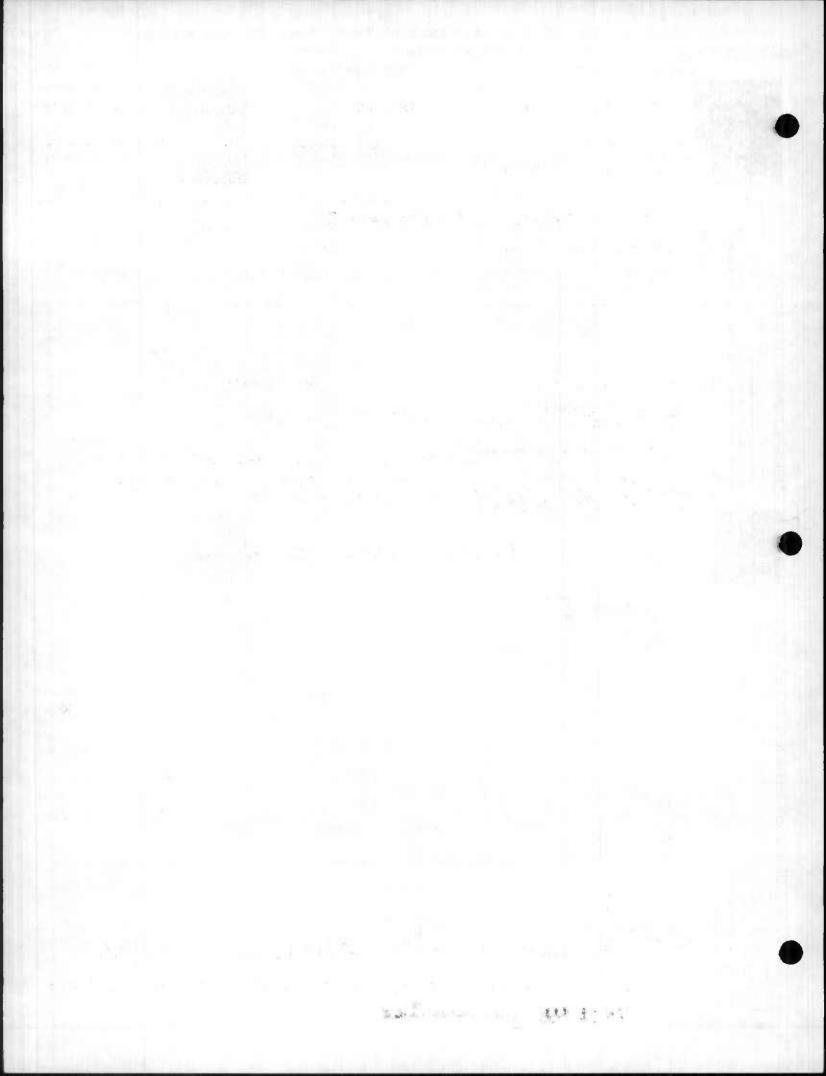
TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: It liem 28 Is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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							9	8	02365	
	1 - FOR STATE OF REGISTRAR	MARYLAND /		IENT OF H		MENTAL HYG				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEAT	TH DAY	YEAR	3. TIME OF OEATH	
	Donald Allan Shi	oley, Sr.				January		998	6:21 PM	М
	4. SOCIAL SECURITY NUMBER 5. SEX	8. AGE (In yrs. lest		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT (Month, Day, Ye	H	8. BIRTH	IPLACE (State or Foreign	
	220-46-4491 1⊠ M 2 □ F	54	YRS.	NTHS DAYS	HOURS MIN.	Oct. 4.		1	land	
	9s. FACILITY NAME (If not institution, give street and number)		96	CITY, TOWN C	R LOCATION OF DE			INTY OF D		
0	Carroll County General H	Hospital		Westmi	nster		Ca	rro1	1	
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c CITY TO	OWN OR LOCAT	ION				10d. INSIDE CITY	
DIRECTOR	Maryland Carroll			w Wind					LIMITS?	
	10e. STREET AND NUMBER		110		ZIP CODE		10a, CI1	TIZEN OF V	WHAT COUNTRY?	\dashv
FUNERAL	310 Main St.			- 1	21776			S.A.		
3		ENT EVER IN U.S. ARI			ENDENT OF HISPAN		ly Yes or No-	14. RACI	E — American Indian,	
	IF YES, GIVE	1 YES 2 N WAR OR DATES	0		2 X NO Specify		C.)	Spec	k, White, etc.	-
BY	3 Widowed 4 🔀 Divorced			<u> </u>					White	
E	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Gr		done during mo		16b, KIND O	F BUSINESS/IN	DUSTRY		
E I	Elementary/Secondary (0-12) College (1-4 or 1 2	5+)	,	,				1		
COMPLETED	17, FATHER'S NAME (First, Middle, Last)	I OWI	ner/op	erator	IS MOTHER'S NA	ME (First, Middle, M	rber s	nop		-
	Donald S. Shipley				Edna S		,			
BE (t9e. INFORMANT'S NAME (Type/Print)	196	. MAILING AO	ORESS (Street a	nd Number or Rural I		or Town, State, Zi	ip Code)		-
5	Edna S. Shipley/mother		310 Ma	in St.	New 1	Windsor,	MD 21	776		
	20e, METHOD OF DISPOSITION 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State	20b. PLACE A	ND DATE OF D	ISPOSITION (Na	me of		c. LOCATION —	- City or To	own, State	
	4 Donetton 5 Other (Specify)	Taylor	rsvill	e Meth			Taylor	svil	le, MD	
	21. SIGNATURED FUNEPAL SERVICE LICENSEE	1. to.	. /	22. NAME AN	ID ADDRESS OF FA		zler F	unera	al Home	
	amarine & x	yary ge			hurch St				21776	
	23. PART I. Enter the disesses, or complications t ahock, or heart failure. List only one of	het ceused the de- ause on each line.	sth. Do not	enter the mo	de of dying, suc	h es cardiec or	raspiratory a	rrest,	Approximate interval Between	en
	IMMEDIATE CAUSE (Final disease or condition	1 0	_						Onset and Dea	
	resulting in deeth)	icular P	upro	112					Minutes	
_	- 0:10	ted Consection (or as a consection)	MALL SO	1001/00	o thu				Tunas	-
9	Sequentielly list conditions, if any, leeding to immediate	O (OR AS A CONSEC	DUENCE OF):	200	~ 1				1	-
S	CAUSE (Disease or injury	O COLLA O COLLA TO (OR AS A CONSEC	ial	Lul	rarctic	2			140	
1	thet initiated evente resulting in death) LAST	O (OR AS A CONSEC	UENCE OF):							
CERTIFICATION	d									
_	PART II. Other significant conditions contributing	to deeth but not re	esuiting in t	he underlying	g cause given in		AS AN AUTOPSY	246	. WERE AUTOPSY FINDING	DS .
MEDICAL	CHF						ES 2 NO		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	:
ME I									1 YES 2 10	
	DID TOBACCO USE CONTRIBUTE TO C	AUSE OF DEA	TH YES	NO [UNCERTAIL	V 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	28. PLAC		Check only one)						
YSI	1 YES 2 NO 1 Inpetient	ER/Outpetient 3	100A 4	Nursing Hom	e 5 🗆 Residence	a Other (Specif	()	4		
	27. MANNER OF DEATH 1 Natural 5 Pending 28e. DATE (Month)	OF INJURY Day, Year)	28b. TIME O	WO	RK?	2ad. DESCRIBE I	IOW INJURY O	CCURED		
BY	2 Accident investigation	OF INJURY — At ho	me form street		YES 2 NO	28f. LOCATION (Street and Alumbu	as os Buost	Doubs Number	-
E	3 Suicide a Could not be determined	g, etc. (Specify)		n, record, anno		City or Town,	State)	or or rigitari	rionis rioniosi,	
	29e. CERTIFIER (Check only Check only 1 CERTIFYING PHYSICIAN: To the best	ot my knowledge de	eth assumed a	d the time date	and alone and due	An Abrahaman (a) an	4	4.4		
COMPLET	(Check only one) 2 MEDICAL EXAMINER: On the basic of								e) end menner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI				(Month, Day, Year)	-
BE	man all the will				0005	1924	>	1-1-	3-99	
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED C	AUSE OF DEATH (ITER	M 27) (Type, Pri	nt)	700	1100		1	, 2177	γ
	Herbert P. Henderson	Jr MD.	12330	luien B	ridae Ru	P.O. Box	190 N	Pu,(4)	indso-MI)	0
	31. DATE FILED (Morith, Day, Year) JAN 15 1998 Julia	RAPIS SIGNATURE)	. 44 19				
	JAN 15 1998 Julia	wenered.	ball							



State of Maryland / Department of Health and Mental Hygiene 9 8

					Certificate of	Dealli	F	Reg. No.	W (,)	
Physician		1. Decedant's Name (First, Middle,	Last)				2. Data of Dea Month	ath Day	Yaer	3. Tima of Deat
/Medical		PATRICIA	ANN		THURSTON		Januar		1998	7:55 pm
Examiner		4a. Facility Nama (If not institution,	give street and number)			4b. City, Town, or Lo	ocation of Death		ty of Death	
		Stella Marris				'imonium,	MD .	Bal	timore	e, Co.
Funeral Director		5. Social Security Number 577-56-2452 Usual Rasidance of Decedant	i. Sax 7. Aga (In y	rs. last birt	Monthe Dave		8. Data of Birtl (Month, Day 5-2-4	h v, Year)		ica (State or Fo y) ington
* w	1	10a. Stete 10b. County	10c.	City, Town	or Location				100	d. Insida City Li
f show		MD. Anne A	rundel Co Se	Wer	Maryla	nd				1 ☐ Yas a
28s	3	10e. Street and Number	24401 00 50		10f. Zip Coda			10g. Citizan o	What Countr	v?
23s or	5	1901 Huguenot	Place		2114	4		USA		,
Hygiena. the than "natural", or items 23a or 28a-f show ent, the Medical Exercitive contifeed at S Completed by Funeral Director		11. Marital Status 1 Navar Married 2 Married	If Yas, Giva	U,S.	13. Was Dacedant of If Yes, specify Cut 1 ☐ Yas 2 ☑ №		ecify Yas or No- Rican, etc.)		ace - Amarica ack, Whita, et	tc.
"natural", o		3 ☐ Widowed 4 ☐ Worced	Year or Detas:	1	Λ.		177		^{ify} Blac	
ygiena. Ner than "naturn It, tra Matical Completed		15. Decedant's (Specify only highest)	Education grade completed)	16a.	Decedant's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of work	ing	16b. Kind of	Businass/Indu	istry
then then		Elementary/Secondary (0-12)	College (1-4or 5+)	Cas	shier	90)		Sales		
		17. Fethar's Nama (First, Middle, La	st)	cu.	JIIICI	18. Mothar's Nam			ima)	
ed oth	ш	Jesse Stringf	,			Arnetta			une)	
th and Mental Hygis 7 is marked other traumatic event, it To Be Cc	-			19h	Mailing Address (Street				n State Zin (Codel
ith ar		19a Informant's Name/Relationship Monica Thurst Wanda Thursto	n (daughter)	Se		not Plac				
ant: If item ury or other	1	20a. Mathod of Disposition 1 【\$\frac{1}{2}	Removal from State	cemeter	Disposition (Name of r, crematory or other pla Hill Cem	,	-12-98		and, N	
Department of Important: If it any injury or once.	-	21. Signature of Funaral Sarvica Lic	Colors Colors)	Tri-State					0011
	4	23a. Pert : Entar tha disaase, or co	omplications that caused the de	eth Don						Approximate ntarval Batwee
Medical caminer		Immediata Ceusa (Final disaasa or condition resulting in daath)	· Met	ني	tell	am	un			Onset end Dea
caminer টু		disaasa or condition resulting in daath)	b		onsequanca of):	am	u			Onset end Dea
an and inel-transit Examiner		disaasa or condition resulting in daath) Sequantially list conditions, if eny, laading to immediata causa. Entar Underlying Ceuse (Diseesa or Injury that initiated avents	b. Dua to	(or es a c	onsequence of):	Cam				Onset end Dea
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

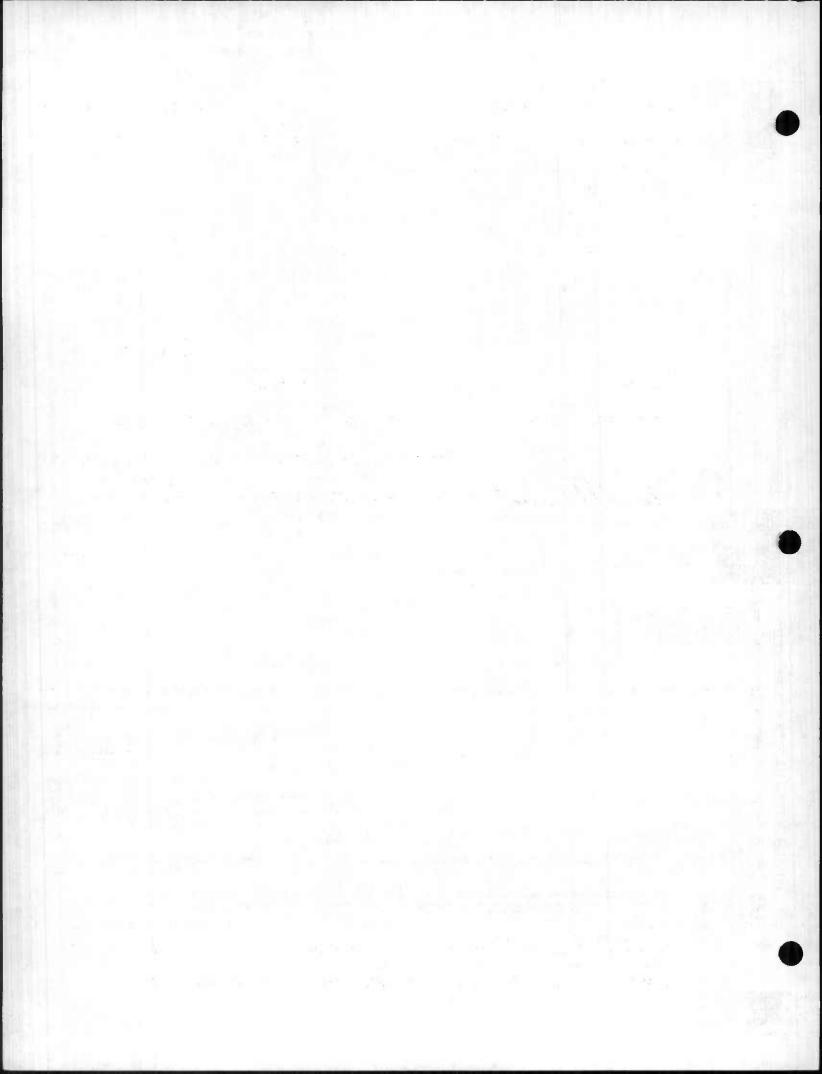
The Ima M. Turner January 10, 199 4e. Fecility Neme (If not institution, give street and number) 3009 Bunker Hill Road Mt. Rainier January 10, 199 4c. County of Mt. Rainier Prince	0 6 0 0 1
/Medical Examiner The Ima M. Turner January 10, 1994 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of 3009 Bunker Hill Road Mt. Rainier Prince	3. Time of Deeth
Examiner 4e. Fecility Neme (If not institution, give street and number) 3009 Bunker Hill Road 4c. County of Mt. Rainier Prince	8 8:00 am
3009 Bunker Hill Road Mt. Rainier Prince	
	George's
Funeral 5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthday) If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) 9	Birthplaca (State or Foraign Country)
Director 223-22-6159 1 M 2 F 80 Yrs. Months Days Hours Min. (Month, Dey, Year) Aug. 26, 1917 Usual Residence of Decedent	Virginia
10a. Stata 10b. County 10c. City, Town or Location	10d. Insida City Limits
Maryland Prince George's Mt. Rainier 106. Street and Number 106. Street and Number 107. Zip Code 109. Citizan of Whe	1Ã Yes 2 ☐ No
10e. Street and Number 10f. Zip Code 10g. Citizan of Whe	et Country?
3009 Bunker Hill Road 20712 U.S.A.	
	American Indian, White, etc.
Specify: Sp	White
3 A Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working) 16b. Kind of Busin	ness/Industry
15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 17	
Homemaker 18. Mother's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Last)	
17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme)	
William B. Reynolds 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Straet and Number or Rurel Route Number, City or Town, Ste	
WITTIAM B. Reynolds Alice Dews 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Straet and Number or Rurel Route Number, City or Town, Sta	ete, Zip Code)
	laryland 20744
20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - Cit	ty or Town, Steta
1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) Fort Lincoln Cemetery 1/12/98 Brentwoo	d, Maryland
20a. Method of Disposition Mathod of Disposition 20b. Plees of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - Cit	
Francis Gasch's Sons Funeral Home, 4739 Baltimore Avenue, Hyattsville,	P.A.
23a. Part Enter the disease, of complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line.	Approximete
Physician	tntervel Between Onset end Death
	de
Immediate Cause (Final disease or condition resulting in deeth)) Jo years
Due to (or es a consequence of):	
Sequantielly list conditions, if any, leeding to immadiate cause. Enter Underlying	
Due to (or es e consequence of): Constitution	
The cause is the funderlying cause. Enter Underlying c	
Ceuse (Disease or injury that Initiated events resulting in deeth) Last Couse (Disease or injury that Initiated events resulting in deeth) Last	İ
d. d. d. d. d. d. d. d. d. d. d. d. d. d	
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Description of the property of	ibute to the cause of death?
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d Signary of the state of the s	Odb Moss autonou findings
24a. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of ceuse
The second of th	of deeth?
	1 ☐ Yes 2 ☐ No
1 Yes 20 No	
24a. Wes en eutopsy performed? 1 Yes 2 No 25. Wes case referred to medical exeminer? 26. Plece of Death (Check only one)	
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1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical exeminer? 1 Yes 2 No 1 No Yes	
1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical exeminer? 1 Yes 2 No 25. Wes case referred to medical exeminer? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Month, Dev Year) 1 Yes 2 No Year) 28b. Time of Injury M 28c. Injury at Work? 28d. Describe how injury occurred work? 1 Yes 2 No Year) 1 Yes 2 Yes 2 Yes 2 Yes 3	
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24a. Wes en eutopsy performed? 1 Yes	
29e. Certifier Check only Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred et the time, date end place, end Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred et the time, date end place, end	or Rural Route Number,
29e. Certifier Check only Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred et the time, date end place, end Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred et the time, date end place, end	or Rural Route Number, her es steted. d due to the ceuse(s)
29e. Certifier (Check only one) 29e. Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end menner stated. 29e. Certifier (Check only one) 29e. Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end menner stated. 29e. Certifier (Check only one) 29e. Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(s) end menner stated. 29e. Certifier (Check only one) 29e. Certifier (Check only one) 29e. Signature end title of certifier 29c. License number 29d. Date signed (A	or Rural Route Number, er es steted. d due to the ceuse(s) Month, Dey, Year)
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Maderal Color of the

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Dacedant's Name (First Middle Lest) 2. Data of Daath **Physician** Month ELMER HARLAND UPOLE JANUARY 15, 1998 6:30 AM /Medical 4a. Facility Nama (If not institution, giva straat and numbar) 4b. City, Town, or Location of Daath 4c. County of Daath **Examiner** CUPPETT & WEEKS NURSING HOME GARRETT OAKLAND if Undar 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number 8. Data of Birth (Month, Day, Year) MAY 10, 19 7. Aga (In yrs. last birthday) 9. Birthpiaca (Stata or Foreign **Funeral** Days Hours 18 M 2□ F MARYLAND 214-07-3349 86 Yrs. Director Usual Residance of Decadant with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits ahow th and Mental Hygiena. 7 is marked other than "natural", or itema 23a or 28a-f ahov treumatic event, the Medical Examination must be notified at 1 ☑ Yes 2 ☐ No Director MD MT. LAKE PARK GARRETT 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 500 H STREET 21550 USA death Funeral 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. Peges 1 end 2 should be filed within 72 hours after or ent of Heelth and Mental Hygiena. ont: If item 27 is marked other than "natural", or iter 1 ☐ Yas 2 🕅 No If Yas, Giva Yaar or Datas: 1 ☐ Navar Marriad 2X Married Baltimore, Maryland 21215-0020 1 Yas 2 No Spacify: Specify: WHITE þ 3 ☐ Widowad 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) RANGER MD FORESTRY DEPT. 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Be **JOSEPH** UPOLE FLORENCE BUTTLER 19a. Informant's Nama/Ralationship (Typa, Print) 19b. Mailing Address (Straet end Number or Rural Routa Number, City or Town, Steta, Zip Coda) CELESTA UPOLE - WIFE 500 H STREET MT. LAKE PARK, MD 21550 or other 1 20a. Method of Disposition 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Removal from Stata permit. Pege Dapertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) PLEASANT VALLEY CEMETERY 1/17/98 OAKLAND, MARYLAND 22. Nama and Addrass of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKALND, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarvai Batwaen Onsat and Daath **Physician** Congestive Heart Failure /Medical Immediata Causa (Final disaase or condition rasulting in death) reals Examine Examiner i or Attanding Physician: The law requires that the death certificate be associted efter death.

Director: After this cartificate has been signed by the ettending physician and burial-transit Sequantially list conditions, if any, leading to immadiata cause. Enter Undarlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): physician s the burial P.O. Box 68760. Physician/Medical Dua to (or as a consequence of). USB BS signed by the e Part II. Other algnificant conditions contributing to death but not rasulting in the undarlying causa givan in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ñ Unknown Division of Vital Records. by 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed page 2 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No funeral director. Be 25. Was casa refarred to medical examiner? 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 41 Nursing Home 5 Rasidance 6 Othar (Specify) 1 ☐ Yas 2 No Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Mennar of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at 1 Naturai 5 Panding 1 Yas 2 No Invastigation 2 Accident 6 Could not be datermined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) illed in by 4 Homicide Hospital 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted. edical 29a. Cartifier completely (Check only one) 2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. To the within 2 29b. Signature and titla of certifing 29c. Licanse number 29d. Date signed (Month, Day, Year) H26154 JANUARY 15, 1998 30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print) 6 P. DANIEL MILLER, D.O. 69 WOLF ACRES DRIVE OAKLAND, MD 21550 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State Registrar **JAN 15**



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath Month 15 Yaar 01 98 9:30 PM Edgar S. Voorhees 4b. City, Town, or Location of Death 4c. County of Death CAROLINE

10d. Insida City Limits

Approximata Intarval Batween Onset end Death

1 ☐ Yas 2 ☐ No

1 Tyas 2 TXNo

Physician /Medical **Examiner**

4a. Facility Nama (If not institution, give street end numbar) DENTON CAROLINE NURSING HOME, INC. If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) August 16, 1919 9. Birthplace (State or Foreign Country) New Jersey 5. Social Sacurity Number 7. Age (In yrs. last birthdey) **Funeral** Hours 1€ M 2□ F Yrs. Director 150-26-8772 78 Usual Rasidance of Dacedant deeth with the Marylend 10a. State 10b. County 10c. City, Town or Location show I is marked other than "natural", or items 23s or 28s-f sho traumatic event, the Medical Exprises must be notified at Director Caroline Denton Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 27292 Burrsville Road 21629 United States Funeral permit. Pages 1 and 2 should be filed within 72 hours efter deet Department of Health and Manual Hygiene, important: if them 27 is trenked other team. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 No Wes Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Maxican, Puano Rican, etc.) Race - American Indian, Black, Whita, atc. 1 Never Married 2 Marriad If Yas, Giva Yaar or Dates: 1 ☐ Yas 2 ☑ No Specify: Specify: Caucasian ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Dairy Farming 8 Farmer 17. Fether's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Ann Sutphin Voorhees James Grant Eleanor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Code) Blanche Hill Voorhees Wife 27292 Burrsville Road, Denton, Maryland 21629 20b. Placa of Disposition (Nama of cametery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Highland Cemetery 1/19/98 Hopewell, New Jersey 22 Maria and Address of Facility A Haue, P.A. 21. Signishing of Funeral Service 12 South Second Street, Denton, Maryland 21629 or complications that caused the deeth. Do not antar tha mode of dying, such es cardiac or raspiratory arrast, ist only ona causa on aech line. ntt. Enter the disaasa, **Physician** /Medical Vascular Arcider Immediata Causa (Final diseasa or condition rasulting in daath) Examiner Examiner physicien and s the burief-transit Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disaase or Injury thet initiated evants rasuiting in death) Last P.O. Box 68760, Physician/Medical **USB 88** ettending p Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the e should be deteched 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, p 24b. Ware sutopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed has certificate Division of Vital or Attending Physician: efter deeth. Director: After this certifice funerel director, 25. Was casa rafarred to medical Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 1□ Yas 21 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) Certification: 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Panding Invastigation 1. Neturel To the Hospital or Attendin within 24 hours efter deeth. To the Funeral Director: Af completely filled in by the fu 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datamined 3 Suicide 28a. Place of injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Certifying Physician: To tha best of my knowledga, deeth occurred at tha tima, data and pleca, and due to the csuse(s) end menner as steted.

2 Madical Examiner: On the basis of axamination and/or invastigetion, in my opinion, daeth occurred at tha tima, date and placa, and dua to the causa(s) and manner steted. Medical 29a. Certifian (Check only one) 29b. Signature and five of certifier 29d. Data signed (Month, Day, Year) 29c. Licensa number

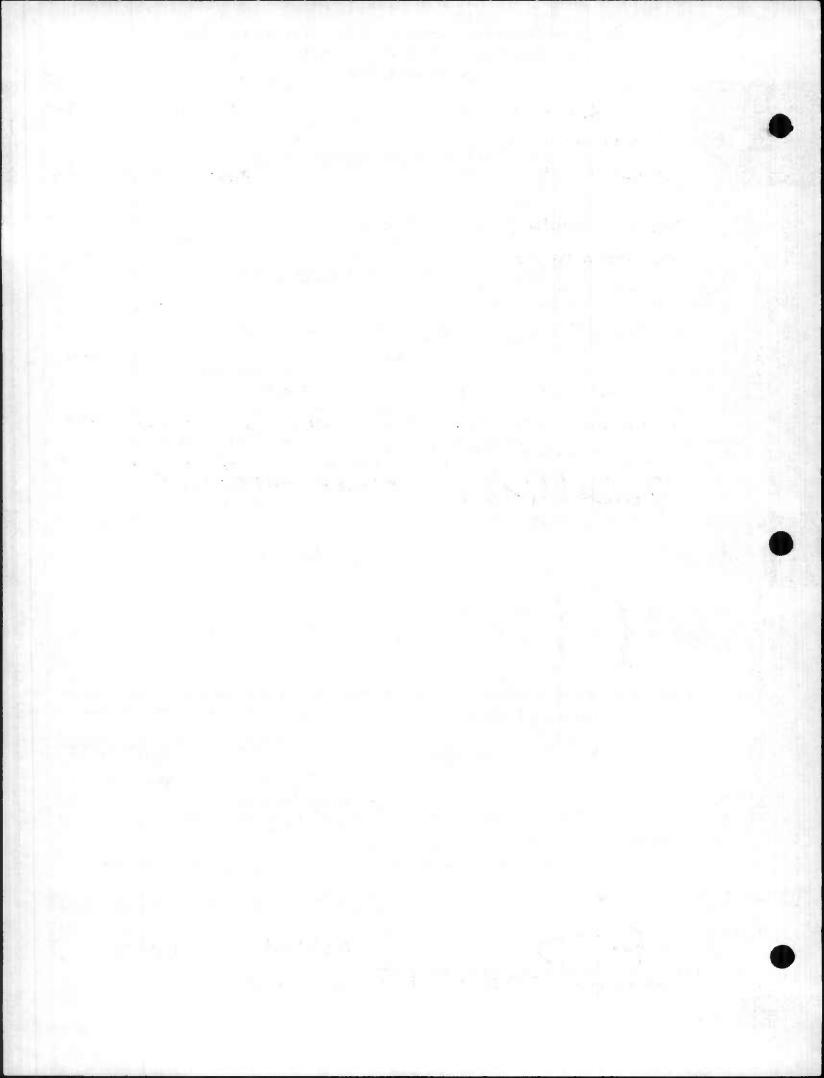
30. Nama and eddress of parson who completed cause of deeth (Itam 23a) (Type, Print) 31. Data filed (Month, Day, Year)

JAN 20 98

32/Registrate Signatura

JAN 20 98 Janton, Md. 21629 51. 320 Registrare Signatura. Pandell

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** January 12,1998 Myrtle D. 1:20 A.M. Varney /Medical 4b. City. Town, or Location of Deeth 4e. Fecility Neme (If not institution, give straet and number) 4c. County of Deeth Examiner Manor Care Nursing Center Prince Georges Largo H Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | 9. Birthplece (State or Foreign Months Days Hours Min. | Min. | March 20,1904 | North Carolina 5. Sociei Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) 1□M 20 F 93 577-05-5302 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Insida City Limits 1 ☐ Yes 2 ☑ No Director Maryland Prince Georges Upper Marlboro 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 600 Largo Road 20772 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes ② ONo If Yes, Giva Yaar or Detes: Was Decedent of Hispenic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 □ Navar Marriad 2 □ Married 1 ☐ Yes 2 No white Specify: þ ₩Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Home maker Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumama) Virgil Homer Deaton Martha Ann Russell 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 5012 Rhode Island Ave. Hyattsville, MD 20781 Rosemary Mason/Guardian 20b. Piece of Disposition (Nema of cemetery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State Washington National Cemetery Jan 21,1998 Suitland, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Takoma Funeral Home, Inc. 21. Signeture of Funerel Service Licensee 23a. Pent. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart allure. List only one cause on each line. 254 Carroll St. NW Washington, DC 20012 Approximete Intervel Between Onset and Death ankinsons Distase Immediate Ceuse (Final disease or condition resulting in deeth) Due to (or es e consequence of): Novic Obstructive Pulmonary Distore Jean Examiner Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Physician/Medicai Due to (or as a consequenca of): Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 X No 3 Probably 4 Unknown 1 Yes þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Was en eutopsy performed? Completed 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? Be 26. Piece of Deeth (Check only one) 1 Yas 2 No Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Yaar) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 Naturel 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Straat end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide 15 Certifying Physician: To tha best of my knowledge, daath occurred et the time, date end plece, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and manner stated. edicai (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. License number wish anong 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Rakesh Arora, M.D. !\$#)) Gallant Fox In. #222 Bowie, MD 20715 31. Dete filad (Month, Day, Year) 32. Registrar's Signature JAN 18 1998

Registrar

Jahra Shoot or Regall

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examiner near be notified at

2 should be filed within 72 hours after end Mental Hygiene. Is marked other than "natural", or ite

permit. Pages 1 end 2 st Depertment of Heelth end Important: If item 27 is m any injury or other traun once.

Physician

/Medicai

Examiner

the ettending physician and ned for use as the burial-transit

signed by

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After

deeth.

i or Attanc after deeti Director:

Hospital 24 hours

To the I

director

funeral

Box 68760.

Records,

Division of Vital

Baltimore, Maryland 21215-0020

with the Meryland

death v

State of Maryland / Department of Health and Mental Hygiene

				Cei	tificate d	of Death	h		leg. No.	Ud	23/1
Di	1. Decedent's Name (First, Middle							2. Data of Dea Month	ith Day	Year	3. Time of Death
Physician /Medical	Mary Beth Wh	ite						January			0510A
Examiner	4a Fecility Name (If not institution	, give street and nun	nber)			4b. City,	Town, or Lo	ocation of Death	4c. County	of Death	
	Laurelwood Nur				Milledge 4 V	1	kton er 24 Hrs.	1.0. (0)	Cec		
uneral	5. Social Security Number	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. I	ast birthday) Yrs.	If Undar 1 Yo Months De			8. Date of Birt (Month, De)	, Year)	Count	**
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A 10	10a. State 10b. County		10c. City	, Town or Lo	cation					10	Od. Inside City Limits
ral', or items 23a or 28a-1 show Evanither must be notified at by Funeral Director	Maryland Co	ecil	E	Lkton							1 ☐ Yes 2 🖺 No
Lec Page	10e. Street and Number				10f. Zip Coo	le			10g. Citizen of V	What Coun	try?
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F	1 ☐ Never Married 2 ☐ Marr		2 XNo		1 Tes, specify €			riloan, atc.)			
l by	3 ☐ Widowed 4 ☐ Divorced	Year or Da	ates:		10 165 2 <u>M</u>	140 Specif	y.		Specify	w Whi	.ce
Completed	15. Deceden (Specify only higher			16a. Deced	dent's Usual Oc kind of work do	cupation	ost of work	ing	16b. Kind of Bu	usiness/Ind	lustry
npien	Elementary/Secondary (0-12)	Coltege (1	-4or 5+)	life.	kind of work do DO NOT use re	tired)			31 - 21	7	
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na n	19a. Informant's Name/Relations							el Route Numbe			C000)
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any injury or other traumatic event, the Medical once. To Be Completed	1 D Burial 2 □ Cremation		State	emetery, crei	natory or other	place)					
<u>Val</u>	4 Donation 5 Other (S		No					1-13-98	North	East	, MD
Duce	21. Signature of Funaral Service	Licensaa		F	Name and Ad Iicks Ho	ome fo	r Fun	erals,	P.A.		
	Donue	S. Hu	kn							, Mar	yland 2192
ician dical niner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)		meum								Approximate Interval Between Onset and Death
1000	resulting in death)			r es e consec	quence of):					1	
nel-transit Examiner		b	Due to /or							i	
Exa	if any, leading to immediate		Du9 (0)	r as a consec	juence or).						
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Completed by Physician/										1	
sched	Part II. Other significant condition			uting in the u	ndariying cause	given in Pa	π Ι.				the cause of death?
V P	Restrictive Lu	ng Diseas	al.						AS SEIMO	O LINE	, 40 OIIKIIOWII
D D	Restrictive Lu Bronchiectae	1						24a. Was	an autopsy	24b. Wa	ara autopsy findings alleble prior to
lete	Bronchectas	0						perfo	rmed?	COI	mpletion of cause death?
dmc								10	es 2 PNo		Yes 2□No
complately filled in by the funeral director, page Medical Certification: To Be Com	25. Was case referred to medical					26 Die	on of Dogs	th (Check only o			2100 22.00
To Be	examiner?	Hospital:	npatient 2 🗆	FR/Outpatier	nt 3□ DOA	Other	_	ome 5 Resid		er (Specifi	v)
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ation at the state of the state	1 ■Natural 5 □ Pendin 2 □ Accident investi		h, Day Year)	Injury		Work? 1 ☐ Yes 2	□No				
Certification:	3 Sulcide 6 Could determ	ned 286. Piece	of Injury - At ho	ome, farm, str	reet, factory, off	ice		28f. Location (S City or Tox	Street and Numb vn, State)	ber or Rura	I Route Number,
edicai (29a. Certifier 1 Certifyin (Check only one)	g Physician: To the Examiner: On the ba	isis of examinet	wledge, death	n occurred et th	e time, dete ny opinion, d	end place, eath occur	and due to the red at the time,	cause(s) and me date end place,	enner es st and due to	sted. the cause(s)
M Me	29b. Signature and fitle of certifia		ner stated.		29c. Llo	ansa numbe	er.		29d. Date signe	d (Month,	Day, Year)
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				02a) (T		, , ,			(T	
	30. Name and address of person MONTE MAKO		or death (Item	West		street	_	ELICTO	N MA	0 7	1921
Ctoto	31. Date filed (Month, Day, Year)		egistrar's Signer		רווייי	7770	-	24(10)	1		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** 4enth AN /Medical 4a. Facility Name [If not institution, giva street and number] 4b. City, Town, or Location of Death 4c. County of Death Examiner If Undar 1 Yaar If Under 24 Hrs. Heonges INTON IANO 5. Social Security Number 8. Date of Birth (Month, Day, MAY 31, 7. Aga (In yrs. last bighday) 9. Birthptaca (State bu Foraign **Funeral** Months Days Min. Hours 1**XX**M 2□ F WISCONSIN Yrs. 395-32-5932 **Director** 61 31, 1936 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumetic event, the Medical Examiner must be notified at 1 ☐ Yes XXNo Director MARYLAND **CHARLES** WALDORF 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 0 238 3792 MT. PLEASANT 20601-4474 UNITED STATES Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1Å Yes ≥ □ No 1953 – If Yes, Giva Yaar or Dates: 1974 Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pagas 1 and 2 should be filed within 72 hours aftar o Department of Haaith and Mental Hygiena. Important: If Item 27 is marked other than "natural" ~ any injury or other traumetic events. 1 Naver Married Married 1 Yes 2 No by 3 ☐ Widowed 4 ☐ Divorced Specify. WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 COMMUNICATIONS ENGINEER COMMUNICATIONS 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOSEPH NICOLAS WAHLEN, SR. CATHERINE MARIE CLOUTHIER 2 19a. Informent's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Code) ANNA MARIE WAHLEN - WIFE 3792 MT. PLEASANT, WALDORF, MARYLAND 20601-4474 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS' CEM., JAN. 22, 1998 CHELTENHAM, MD ale 19. The have THE HUNTI FUNERAL HOME, INC. MARK G. BROHAWN M00053 P.O.BOX 156, WALDORF, MARYLAND 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medicai 88 for usa Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings aveilable prior to completion of causa of deeth? 2500 1 Yes 1 ☐ Yes 2 ☐ No funaral director, Be 25. Was case referred to medical 26. Pleca of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Ainpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Pending Investigation 1 Natural 2 Accidant 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homlcide

Records, P.O. Box 68760 Division of Vital

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physician and s tha burial-transit or Attending Physician: The law requires that the death cartificate be executed bean signed by tha should be datached page 2 s cartificata After this Hospital

24 hours after death. filled in by edicai To the Hosp within 24 ho To the Fune completaly f

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier affecting MI)

29c. License number D24208 29d. Date signed (Month, Day, Year)

1.15.1994

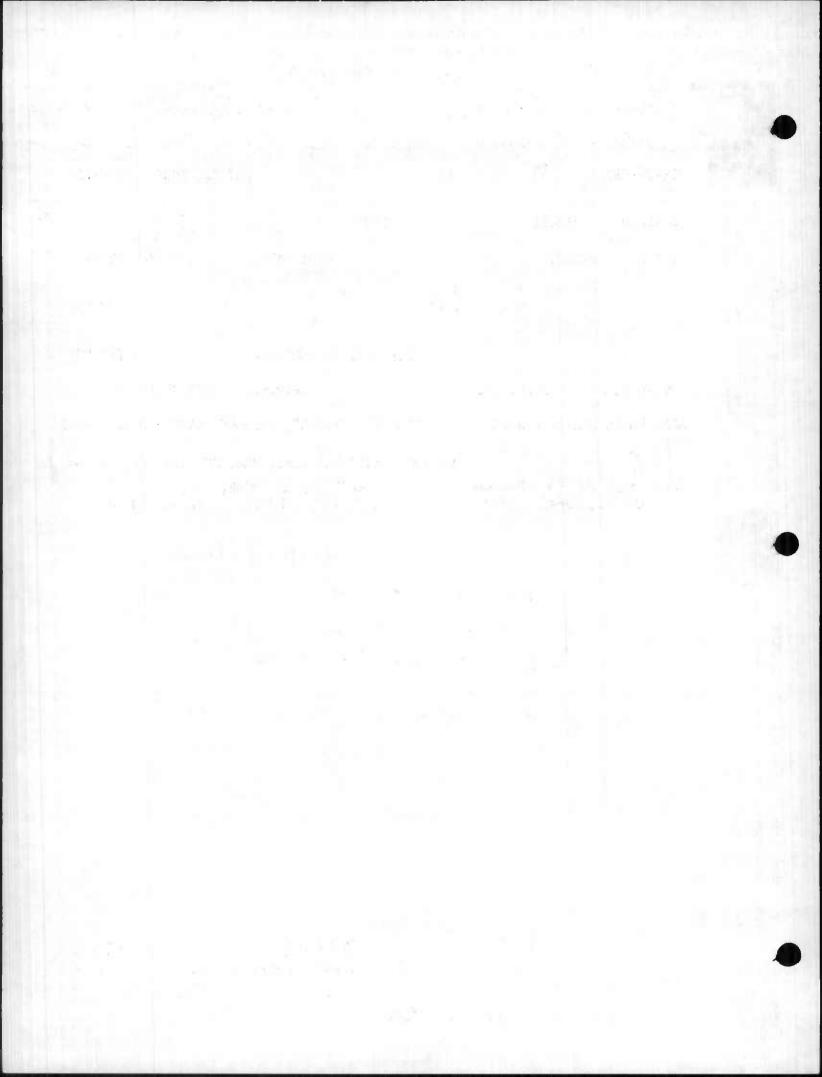
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 8926 COORfy and All APYLHASAN U ANSINI MI) Clinton Mg. 2003

State Registrar

JAN 2 0 1998

31. Date filed (Month, Day, Year)

32. Registrar's Signature Alli Shodson Rarlall



State of Maryland / Department of Health and Mental Hygiene.

1 /	Department of Health and Mental	Hygiene	į
	Certificate of Death	Reg. No.	ļ

ΓE			otato ot marytan	Certificati	e of Death		Reg. No.	023	13
ľ	Physician	Decedent's Nama (First, Middle, Les		White		2. Dete of De Month JANUA	Dey Dey	Yeer	Tima of Death
	/Medical Examiner	4a Facility Nama (If not institution, give				n, or Location of Daat	h 4c. County	of Death	
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9	faryland show dat	Usual Residance of Decedent 10a. Stata 10b. County Maryland Prince	George's	, Town or Location	Upper M	lar1boro			nsida City Limits
	death with the Maryland one 23e or 28e-f show count be notified at neral Director	10e. Street and Number 9017 South Che	erry Lane	10f. Zip			10g. Citizan of 1	What Country?	
020	urs after function by Fu	11. Maritel Status 11 Naver Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Evar in U, Armed Forcas? 1 ☐ Yas 2 No if Yes, Give Yaar or Datas:	S. 13. Was Deced If Yas, spec	lent of Hispenic Origi ify Cuban, Mexican,	n? (Specify Yas or No Puarto Rican, atc.)	o- 14. Rac Blac Specifi	ce - Amarican In ck, White, etc.	
1215-0020	E	15. Decedant's Ed (Spacify only highast gra Elementery/Secondery (0-12)		lifa. DO NOT us	rk dona during most (sa ratired)	of working	16b. Kind of B	usinass/Industry	
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, Maryland	d 2 shoth and 7 is muturn	19e. Informent's Name/Ralationship (7 Dorothy White/Mc	Type, Print)	19b. Malling Address 9017 Sout			er, City or Town,		
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Balt	pemit. Pege Department of Important: If any injury or anse.	21. Signature of Funaral Sarvice Lican	A .	TD	d Address of Facility Jenkins Landover	Funeral Ho	ome dover. M	arvland	20785
	Physician /Medical Examiner	23a. Part1. Entar the diseasa, or companies shock, or haart fails ra. List only limmadiata Ceuse (Final disease or condition rasulting in daath)	a Gunshot	Wound	e of dying, such es c	Ball	arrast,	App Intal Ons	roximata rval Batween at end Deeth
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x 68760,	ficata be physicia s the bur edical	Sequentially list conditions, if any, laeding to immadiata cause. Enter Undarfying Ceusa (Diseese or injury that initiated avants rasulting in daath) Last	CDua to (or	as a consequance of):					
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al Re	ystcian: Tha law is certificata has director, page 2					7	Yes 2□ No	1©Yes	2 □ No
of Vital	Physician: this certific ral director,	25. Was casa refarrad to medical axaminar? 1 🗗 Yas 2 🗌 No	Hospital: 1 ☐ Inpatiant 2 ☐	ER/Outpetient 3 DC	Othor	of Death (Check only sing Homa 5 \subseteq Ras		ner (Specity)	
o uo	6 6 = 1	27. Mennar of Deeth 1 Neturel 5 Panding 2 Accidant invastigation	28e. Deta of Injury (Month, Day Yaar)		8c. Injury et Work? 1 □ Yas 2 ☑ N	28d. Dascribe	how Injury occur		CENE —
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	The Hospital The Funds The		vsician: To the best of my know iner: On the basis of examinat						
	Med	29b. Signature end titla of certifier	04/	290	. Licensa number		29d. Data signa		
	161	30. Name and address of person who	completed cause of death (fram	23a) (Type Print)	OCME		JANUARY	08, 19	98
	(4)		who	111 Penn S	Street, Ba	ltimore, 1	Maryland	21201	

State Registrar

31. Data filad (Month, Day, Yaar)



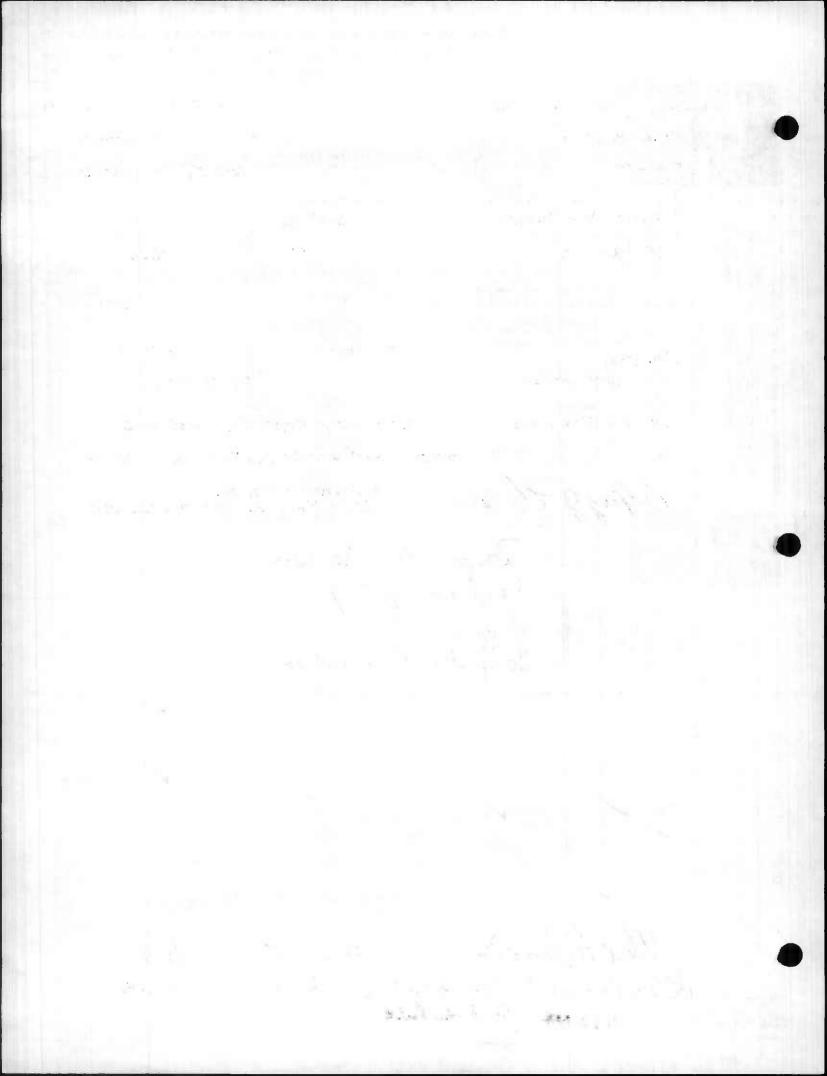
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State of Maryland / Department of Health and Mental Hygiene 9 8

Physic	ian	1. Decedent's Name (First, Middle, Las.						2. Dete of Dea Month		3. Time of Death
/Medi		Joseph L. Willi						1	cy 8, 1998	
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uneral irector		240-22-2323	9x 7. Aga	a (In yrs. las	st birthday) Yrs.	If Under 1 Yea Months Day		8. Date of Birth (Month, Day March	(, Year)	Birthplaca (Stata or Foreig Country) Orth Carolin
how		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	eation				10d. Inside City Limit
Till Bar	Director	Maryland Prince G	eorge's	River	rdale					1 X Yes 2 □ N
or 28	Sire	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
230	100	5017 Oglethorpe S	treet			20737			U.S.A.	
is marked other than "naturel", or items 23e or 28a-f show aumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 X Yes 2 N If Yes, Give Yaar or Datas:	Evar in U,S. Io		Vas Decedant of Yes, specify Cu ☐ Yes 2 1 No	f Hispanic Origin? (Spuban, Mexicen, Puerto o Specify:	pecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	
cal	ted	15. Decedent's Edu	ucetion		16a. Decede	ent's Usual Occi	upation		16b. Kind ot Busine	ss/Industry
E S	Completed	(Specify only highest grad Elementery/Secondary (0-12)	College (1-4or 5	+)	life. D	O NOT use retir	e during most of work red)	king		
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arke atic	2	John Henry Willis					Mary E.			
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item 27 i other tra		Mary U. Willis - 1 20a. Method of Disposition	Wite	20h Pia				t, River	dale, Mar 20c. Location - City	yland 20737
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dury		4 Donation 5 Other (Specify)		Rose		Cemeter				orth Caroli
important: If i any injury or once.		21. Signature of Funeral Service Licens	22				less of Facility Gasch's So timore Ave			
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sician edical miner	7	Immediate Cause (Final disease or condition	METAS	STAT(1 c 1	prost	HE CA	WCER		Onset end Death
	-	resulting in death)		Due to (or a	as a consequ	uance ot):				
ısit	nin		b. ————							
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ate he	mo;							1 🗆 Y	es 20 No	1 ☐ Yes 2 ☐ No
s certificate director, peg	Be	25. Was case reterred to medicel examiner?					26. Place of Dea	th (Check only o	ne)	
dire.	2	1 Ves 2 No	Hospital: 1 ☐ Inpatie	nt 2 EF	R/Outpatient	3 DOA	Other: 4 Nursing H	ome 58 Resid	ence 6 Other (S	(pecify)
After th		27. Manner of Death Naturel 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year) 2	8b. Time of Injury	28c. Inj W	jury at ork? □ Yes 2 □ No	28d. Describe h	ow Injury occurred	
2 6	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ry - At hom . (Specify)	e, farm, stre			28f. Location (S City or Tow	Street and Number or n, State)	Rural Routa Number,
Director: After this c d in by the funeral director		29a. Certifier Certifying Physical Exami	ner: On the basis of	exeminetion	edge, death n end/or inve	occurred et the estigetion, In my	time, dete and place, opinion, death occur	and due to the or	ause(s) and menner date end place, end	as stated. due to the ceuse(s)
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To the Funeral Directo completely filled in by the	Medical		end manner sta			29c. Lice	nse number	2	29d. Date signed (Me	onth, Day, Year)
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State of Maryland / Department of Health and Mental Hygiene 8

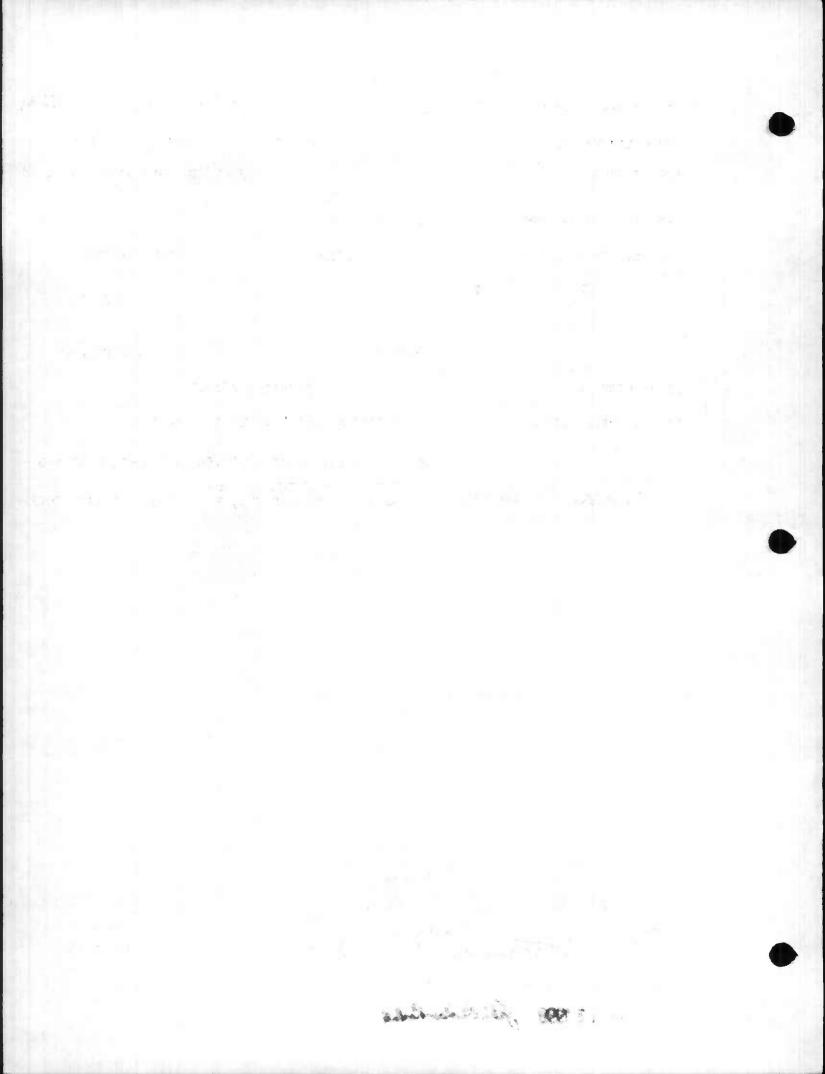
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Funeral Director		5. Social Security N 579-46-180	lumber 6.	Sex XX M 2□ F		rs. lest birthday	/) If Under Months	1 Year Days			8 Date of Bi		9. Birt	thplace (State or Fo
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207	octo	Mary 1 and		George's					oel Oak	S				XX Yes 2[
23a or 2 ust be n	Funeral Director	1320 Dur	mber Bbar Drive				10f. Zip	Code	20743			10g. Citlzen	of What Co	ountry?
Department of Hauth and Mantal Hygiana. Department of Hauth and Mantal Hygiana. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic event, the Maulcal Examinal mant be notified at another.	by	11. Marital Status 1 □ Never Marr 3 □ Widowed	ied 2☐ Married	12. Was Dec Armed For 1 Yes If Yes, Gi Year or D	2 No	U,S. 13	Was Deced If Yes, spec			gin? (Sp n, Puerto	ecify Yes or N Rican, etc.)		Race - Ame Black, White Broify: Bla	
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than than	dmo	Elementary/Seco		College (1-4or 5+)	life.	Cab Dr		d)			Cab 1	Industr	v
Department of Haalth and Mantal Hygiana. Important: If item 27 is marked other than any injury or other traumatic event, Ital Mance.	To Be Co	12th gra	de (First, Middle, Last Willie Wil	n liams					18. Mothe	er's Name	(First, Middle Comilla	, Maiden Sun		J
and Man le marke aumetic		19a, Informent's Na	ame/Relationship	(Type, Print)		19b. Mai	ling Address	(Street	end Numbe	er or Run	al Route Numb	er, City or To	wn, Stete, 2	Zip Code)
Haalth m 27 I		Mr. Willie		(Father)	Frail	1320	Dunbar	Driv	e Cha	pel 0	aks, Mar			
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Department Important: If any injury or once.		21. Signature of Fu	6 0	11	Pleis		Roll	ins F	Impral	Homo	, Inc.	enten D		0010
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State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Beeth ~ 3 PM 2. Date of Death Month **Physician** 1998 MARK WORRELL Jan 0 /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 9220 LIVERY LANE "L" HOWARD COUNTY LAUREL if Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Dete of Birth (Month, Dey, Year) NOV 20, 19 7. Age (In yrs. lesf birthday) 9. Birthpiece (State or Foreign **Funeral** 1X M 2□ F Deys Hours Yrs. 1961 WASHINGTON, DC Director 36 579-92-9943 Usual Residence of Decedent the Marylend 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 🖾 No Director MARYLAND HOWARD COUNTY LAUREL 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? death with 9220 LIVERY LANE "L" 20723 UNITED STATES Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American indien, Bleck, White, etc. 11. Maritel Status should be filed within 72 hours after of Mental Hygiene.
marked other then "natural", or iter 1 ☐ Never Merried 2 Nerried Baltimore, Maryland 21215-0020 1□ Yes 2♥ No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed Vent, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) DRIVER TRUCKING COMPANY 11 permit. Peges 1 end 2 should be file Depertment of Health end Mental Hy Important: If frem 27 is marked other any Injury or other traumatic event once. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be 2 ALLEN WORRELL LORRAINE BUTLER 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9220 LIVERY LANE "L", LAUREL, MARYLAND TINA WORRELL, WIFE 20723 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 K Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 1/13/98 BRENTWOOD, MARYLAND FORT LINCOLN CREMATORY 21. Signetura - Funerel Service Licensee 22. Neme end Address of Fecili FORT LINCOLN FUNERAL HOME ulun 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 23a. Part 1. Enter the disease or complications that caused to deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediete Cause (Final disease or condition resulting in death) · Counshot wound to head Seconds Examiner Due to (or es a consequence of): Examiner The law requires that the deeth certificate be executed physician and s the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): ettending pl signed by the e Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed page 2 s certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Attending Physician: 25. Wes case referred to medical exampler? Be 28. Place of Deeth (Check only one) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No SIL funeral 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending Self-inflicted gunshot to head deeth. N 310 Investigation 1 Yes 2 No Jan 6 98 2 Accident ofter deeth Director: 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö 24 hours Hospitat 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Cartifier To the Hosp within 24 ho To the Fune completely fi Medical (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Deput ME -, MD 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 4565 Hemlock Come way Eureal City MV 21042 PATRICE A-TOIL MYD 31. Dete filed (Month, Dey, Year) 32 Registrar's Signeture State JAN 1 3 199 Registrar

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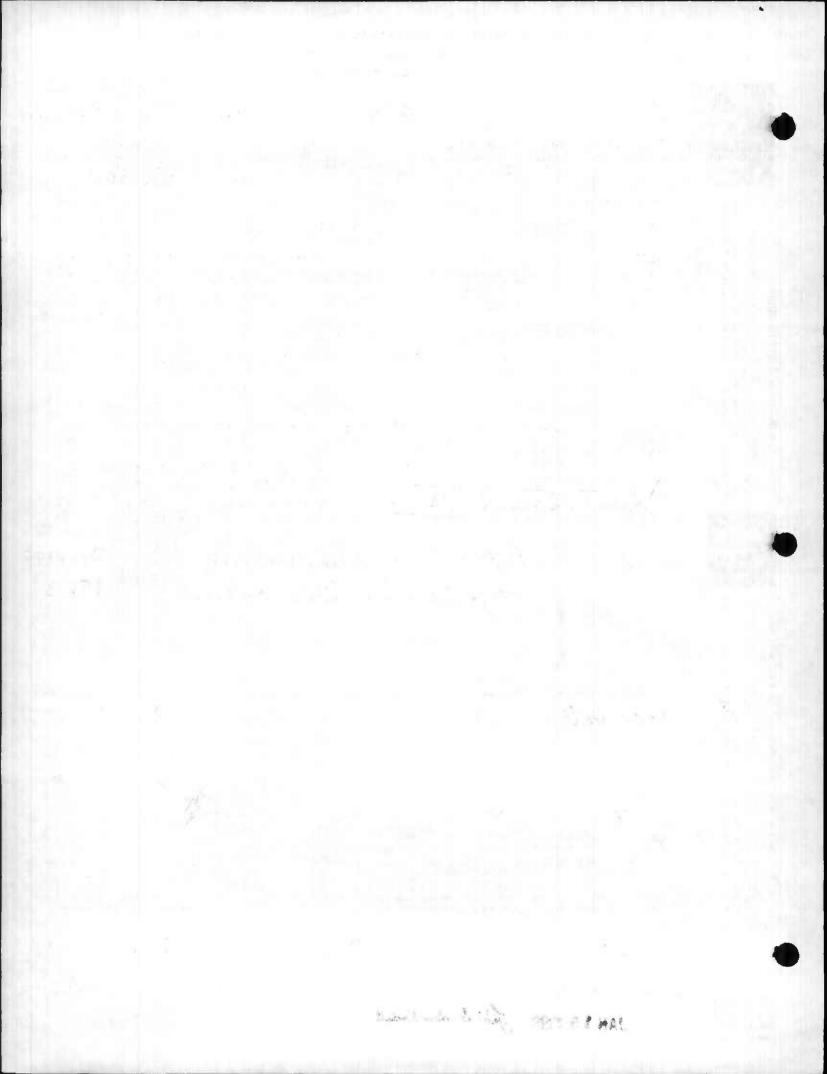
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 3. Time of Deeth 2. Deta of Death WARING , SR. **Physician** Month WILLIAM 11:00 A.M. 10 /Medicai 4e. Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner WASHINGTON ADVENTIST HOSPITAL IAKOMAKK. MONTGOMERY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 5 5 5 1. 5. Social Security Number 577-07-6877 6. Sex 102 M 2□ F 7. Age (In yrs. last birthdey).

8 4 Yrs. 9. Birthplace (State or Foreign Country)
LEXINGTON, S.C. Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at DIC WASHINGTON 1 Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20019 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. If them 27 is marked other than "natural", or thems 23: 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0020 1 ☐ Yes 2 1 No þ 3 ₩Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

RAILROAD - RED CAP 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry
RAILROAD Elementery/Secondary (0-12) College (1-4or 5+) 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middla, Last) SAMUEL FLORA STROTHER WARING 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) -LORA RICHARDSON | DAUGHTER 6708-BLACKLOGST., CARMODY HILLS, Mp. 20743 20b. Place of Disposition (Neme of cemetery, cremetory or other placa) 20e. Method of Disposition 20c. Location - City or Town, Stata Date permit. Pages Department of Important: if it any injury or o 1/16/98 1 Bunel 2 □ Cremation 3 □ Removel from Stata SUITLAND, MD. LINCOLN MEM, CEM, 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility 23a. Part1. Enter the disease, or confidential that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, **Physiclan** Immediete Cause (Finel disease or condition resulting in deeth) /Medical Examiner Examine Sequentially list conditions, if any, leeding to Immadiate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Physician/Medical 9 8 880 Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Division of Vital Records, py 24e. Wes en eutopsy performed? 24b. Were eutopsy findings lax accident eveileble prior to completion of cause of deeth? .tlei 1 Yas 2 No 1 □ Yes 2 □ No 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 KNo 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturel 1 Yes 2 No Director: / 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) or A 4 Homleide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) Medical end manner stated. 29d. Date signed (Month Dey, Yeer) 29b. Signature and tille of cartifier 29c. License number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MD. 3503 PERRY STREET, MOUNTRAINIER. MD207/2 31. Dete filed (Month, Dey, Year) 32. Registrer's Signetura Son Moder Redall



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Deeth Month January 20,1448 Percell A. Anderson 4c. County of Daath 4a. Facility Nema (If not institution, give street and number, 4b. City, Town, or Location of Death Baltimore Greneral if Under 24 Hrs. Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. 5. Social Security Number last birthday) Days XIXM 2 F 72 Yrs. 237-42-4761 10-25-25 NC Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits Md. NA Baltimore XIXIYes 2□No 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 707 West Lanvale Street 21217 USA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 1 No it Yes, Give Yaar or Dates: Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxicen, Puarto Rican, etc.) Rece - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Black 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 7th Grade Labor Cement Company 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Name (First, Middla, Last) Benton Anderson Gertrude Withers 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 21217 Olivia Anderson 707 W. Lanvale Street Baltimore, Maryland 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata Md. 20a. Mathod of Disposition 1 D'Burlal 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest VA Cem. 01-30-98 Owings Mills 21. Signatura of Funaral Sarvice Licensal 22. Name end Addrass of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue mour 23a. Part1. Entar the disease, or or nolications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Causa (Final disaasa or condition rasulting in daath) Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated exists) Dua to (or as a consaquance of):

Physician/Medical Examiner P.O. Box 68760. Division of Vital Records. þ Completed Hospital or Attending Physician: Be Medical Certification: To 24 hours efter deet Puneral Director:

Physician

/Medical

Examiner

by Funeral Director

Completed

Be

Funeral

Director

items 23a or 2 iner must be n

the Medical

important: If ihem 27 any injury or other to

Physician /Medical

Examiner

rasulting in daath) Last	Due to (or as a consequance	• of):	
Part II. Other significant conditions	s contributing to death but not resulting in the underly	ing causa givan in Part I.	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
			24a. Was an autopsy performed? 24b. Wara eutopsy findings available prior to completion of cause of daath? 1 Yas 2 No 1 Yas 2 No
25. Was casa ratarrad to madicel axaminar?		26. Place of Daath	(Check only ona)
1 Yas 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	□ DOA Othar: 4□ Nursing Hor	me 5 Rasidance 6 Othar (Specify)
27. Manner of Death 1 Watural 2 Accidant 5 Panding Invastiga	28a. Data of Injury (Month, Day Year) 28b. Tima of Injury M	Work?	28d. Dascribe how injury occurred
3 Suicida 6 Could no datarmin		actory, office	28t. Location (Straat and Number or Rural Routa Number, City or Town, Stata)
29a. Cartifiar 1 Cartifying (Check only one) 2 Medicel Ex	Physicien: To the bast of my knowledge, death occu aminer: On the basis of examination and/or investige and manner stated.	irred at tha tima, data and place, a ation, in my opinion, daath occurre	and dua to tha causa(s) and mannar as stated. ad at tha tima, data and place, and dua to tha causa(s)
29b. Signature and title of certifier		29c. Licensa number	29d. Data signad (Month, Day, Year)

821 N. EUTAWST

SUTE 407,

January 26th 1998

MD21201

State Registrar

31. Data tilad (Month, Day, Year)

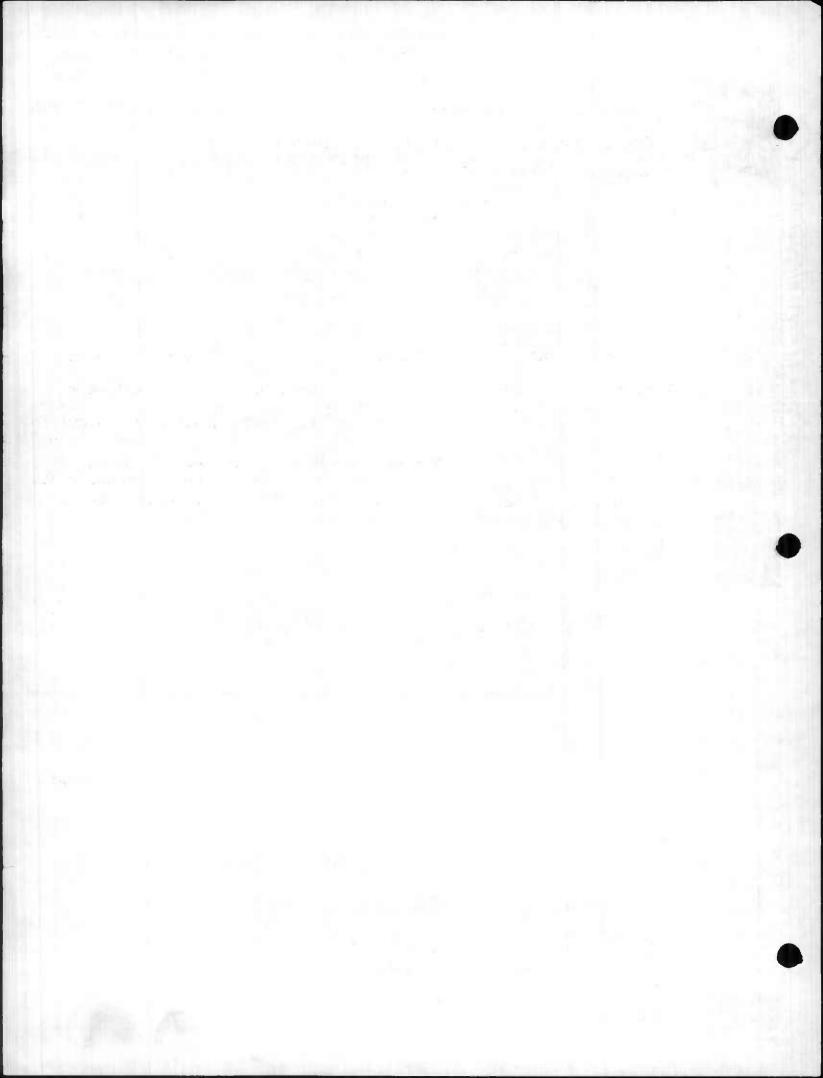
32. Ragistrar's Signatura ulia Bavidson

asantha cuma un

30. Nama and addrass of person who complated causa of death (ttam 23a) (Typa, Print)

VASANTHA KUMAR

within 24 hours effer der To the Funeral Director completely filled in by th



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** HALLN 5. FINGREWS 5:32 Am January 28, 1998 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 328 Colony Pt Place Edgewater Anne Arundel If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 180 M 2□ F Months Deys 63 412-50-2496 Director Nov. 8, 1934 Tennessee Usuel Residenca of Decedent with the Marylend 10c. City, Town or Location 10a State 10b County 10d. inside City Limits Pages 1 end 2 should be filed within 72 hours after death with the Marylen neat of Health and Mental Hygiene.
Int: if item 27 is marked other than natural; or items 23s or 28s-f show my or other than the hygiene.
Inty or other traumatic event, the Medical Exertine must be notified as 1 Yes 2 No Director Anne Arundel Edgewater 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 328 Colony Pt Place 21037 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 № Yes 2 □ No If Yes, Give Yeer or Detes: 1957–77 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritel Stetus Bleck, White, etc. 1 Never Merried 2X Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: b White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Program Manager U.S. Air Force 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Jeff Joe Andrews Mary Lou Cole 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Sally Andrews - Spouse 328 Colony Pt. Place, Edgewater, MD 21037 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, crematory or other pleca) 20c. Location - City or Town, State Date permit. Pages Depertment of Important: if its any injury or o 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from State 1/30/98 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory Baltimore, Maryland 21. Signeture of Funeral Service Licanses 22. Name end Address of Fecility Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis,
shock, or heert failure. List only one ceuse on each line.

Hardesty Funeral Home, P.A.
Ridgely Avenue, Annapolis,
shock, or heert failure. List only one ceuse on each line. MD Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final Esophague HoleNOCATUNOMA diseese or condition resulting in death) Examiner Due to (or es e consequence of): Examiner end I-transit the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last Due to (or as e consequenca of): physician er s the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): 98 use to signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 12 Yes 2□ No 3 Probably 4 Unknown ò 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed certificate has b 1 Yes 2 No 1 TYes 2 No Be 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end placa, end due to the ceuse(s) end menner stated. 29a. Certifier (Check only one)

29c. License number

completed cause of death (Item 23a) (Type, Print)

M.D.,

Julia Davidson-Randall

32. Registrar's Signeture

111,

ole

29d. Date signed (Month, Dey, Year)

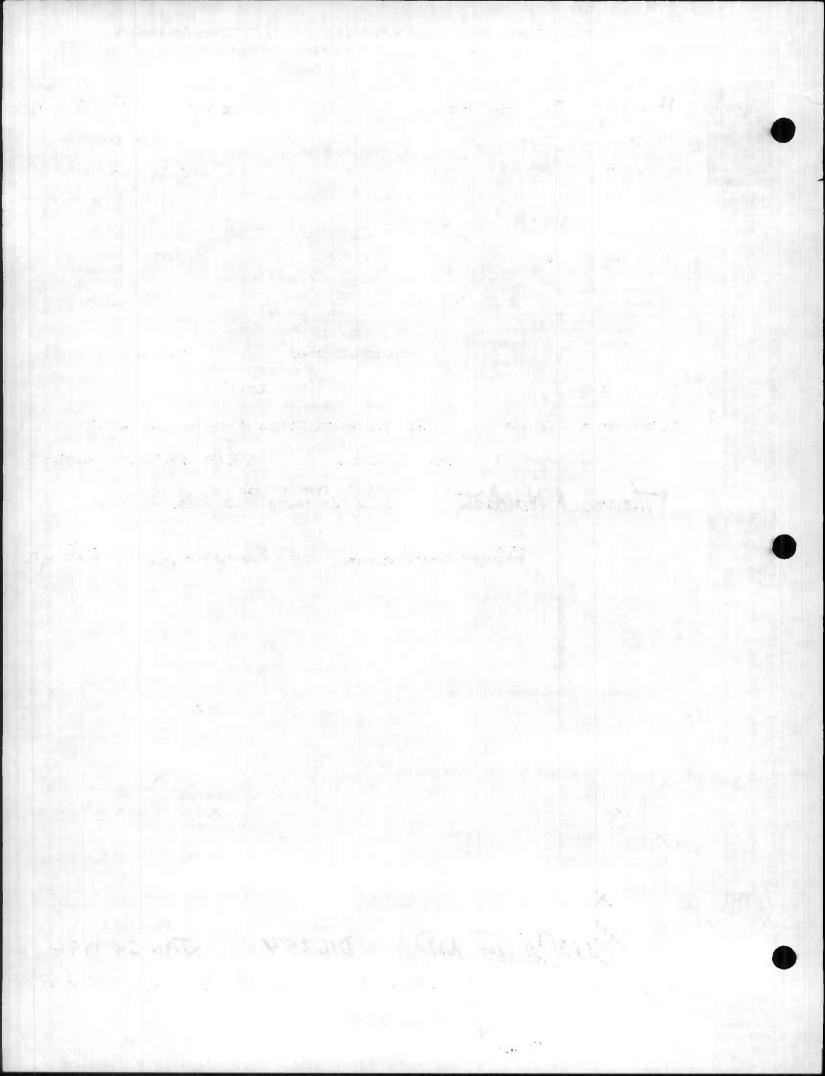
900 Bestgate Road, annap, MD 21401

State Registrar 29b. Signature and to of certifie

30. Neme end eddress of person

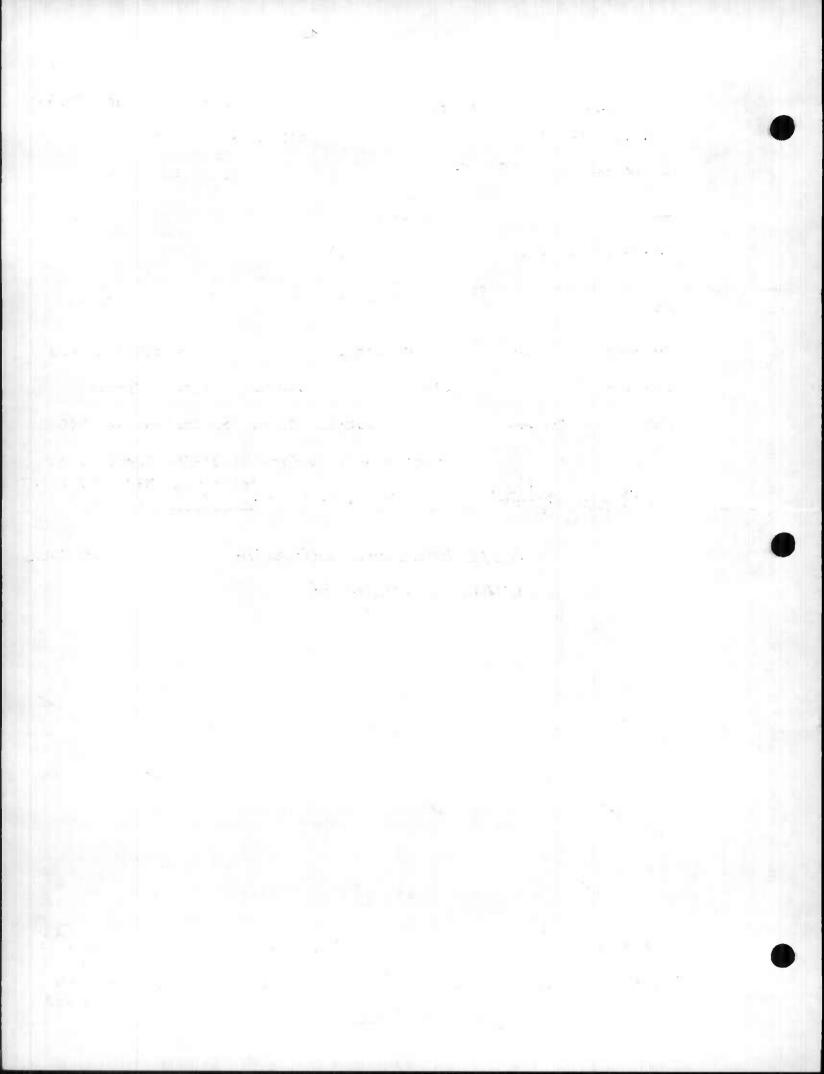
31. Dete filed (Month, Day, Year)

W.



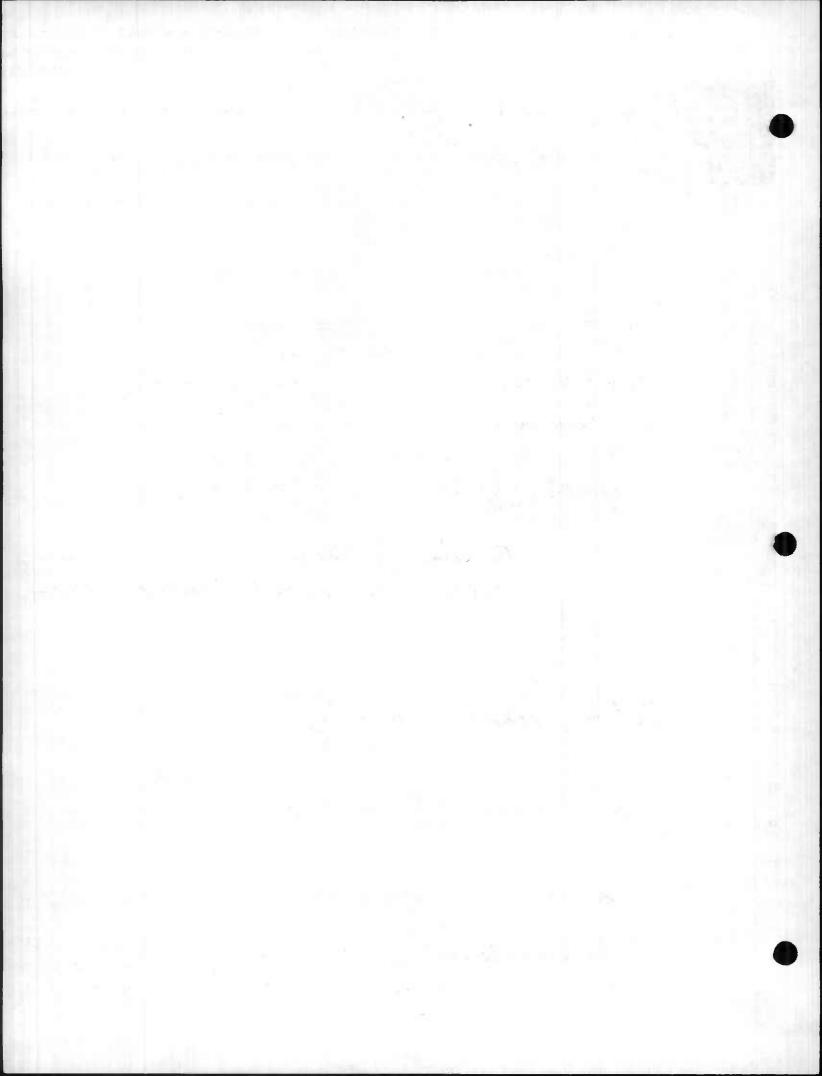
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Month **Physician** 06:06am Jan. 98 22, Irene Brown /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not Institution, give street end number) Examiner Sinai Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1 M 201 83 Vre 212-18-4838 **Director** 01 - 26 - 15Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland and Chaulh and Mantal Hygiene. And the fire 23 and 23 and 24 shown that if them 27 is mereked other than "natural", or items 23a or 28a-f show iny or other traumatic event, has Modical Examiner mant be notified at iny or other traumatic event, has Modical Examiner mant be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits XYes 2 No Baltimore Director NA 10e. Street end Number 10f. Zip Code 10a, Citizen of Whet Country? 4800 Seton Drive 21215 USA Funeral 13. Wes Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 14. Race - American Indian, 12. Was Decedant Ever in U.S. Armed Forces? 11. Marital Status Bleck, Whita, atc. 1 Never Married 2 Married 1 ☐ Yas ♀ No Baltimore, Maryland 21215-0020 1□ Yes 2□ No Specify: Specify 3 Widowed 4 □ Divorced P Year or Dates: Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Domestic various trades 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Charlie Harris Wood Harris Bertha 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) John Godbee 1717 Laurel Street San Carlos, CA. 94070 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition Date 1 X Buriel 2 ☐ Cramation 3 ☐ Ramovel from Stete permit. Page Department of Important: If sny Injury or 4 ☐ Donation 5 ☐ Other (Specify) Voshell Mem. Gardens 01-31-98 Dundalk, Md. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Baltimore, Maryland @1202 Dan WM.C.MArch FH 1101 E. North Avenue 23a. Part 1. Enfer the disease, or complications that caused the death. Do not entar tha mode of dying, such es cardiac or raspiratory errest, shock, or heart tailure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical . ACUTE BACTERIAL SEPTICEMIA 24 Itours Examiner Examine BILATERIAL PNEUMONN The law requires that the death cartificate be axecuted attanding physician and for usa as the buriai-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence ot): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy tindings available prior to completion of ceuse of death? should b 24a. Was an autopsy performad? Completed Is cartificata has I director, paga 2 s 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case reterred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2DNo 2 1 ☐ Inpatient 2 ☑ ER/Outpatient 3□ DOA this funaral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: Aftar 5 Pending investigation 1 Yes 2 No death. Director: A 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 3 To the Hospital or A within 24 hours aftar To the Funeral Direct compiataly filled in by 4 Homicide edical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, and dua to the ceuse(s) end manner es steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. (Check only 29d. Dete signed (Month, Dey, Year) 29b. Signatura and titla of certifiar 1 weran & 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Heights Avenue Baltimore, MD 7220 31. Dete filed (Month, Dey, Year)

JAN 3 0 1998 32. Registrer's Signeture State kha Davidson Registrar



State of Maryland / Department of Health and Mental Hygiene 8 12382

					Certif	icate of	Death		Rac	. No.	400	006
Physic /Med		1. Decedent's Nama (First, Middla, La	Botem	ar				M	ete of Deeth onth JUARY	Dev	Yaar 1898	3. Time of Deeth 12:15 pu
Exam		4e. Fecility Name (If not institution, gir	va street and number)-				4b. City, Tow	n, or Location	of Death	4c. County	of Death	
		Lorien Nursi						olumb:			Howar	d
Funera Directo			Sex 1 □ M 2 T F 7. Age	95 Y		Undar 1 Yea onths Deys		Min. (N	ate of Birth fonth, Dey, Y B. 23	^(ear) , 1902	9. Birthpled Country Mary	ce (State or Foreign 71 and
/land		10a. Stete 10b. County		10c. City, Town	or Location	on					10d	. Insida City Limits
Man	to	Maryland Howar	d			Co1	umbia					1□Yes 2√ No
or 28	Director	10e. Street end Number			1	Of. Zip Code			100		Whet Country	17
23e		6334 Cedar L	ane			2	1044			USA		
72 hours efter deeth with the Maryland natural; or items 23e or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Wes Decedent E Armed Forces? 1 Yas 2 No If Yes, Give X Year or Dates:			Dacedent of s, specify Cu Yes 2 No	Hispanic Original Den, Mexicen, Specify:	in? (Specify Y Puarto Rican	es or No- , etc.)		ce - Amarican ck, White, etc	
d within 72 hours ef giene. Ir then "neturel", or	ted	15. Decedent's E	ducation	16e. I	Decedent'	s Usuel Occi	upetion	of working	16	b. Kind of B	usiness/Indus	stry
within ene.	Completed	(Specify only highest gn Elementery/Secondery (0-12)	College (1-4or 5+	-)			e during most red)					
e filed w al Hygier other th				Ja	init	orial	Worke				pital	
of a b	To Be	17. Fathar's Name (First, Middla, Last John C. Mi	*					's Name <i>(Firs</i> rgaret			,	
2 sh end is m	ľ	19e. Informent's Name/Relationship (Type, Print)	· 19b.	Meiling A	ddress (Stree	et end Number	or Rural Rou	te Number, (City or Town	State, Zip Co	ode)
C # 01 F		Margaret Germa	n/niece				ood Dr					21146
of of		20a. Method of Disposition 1 ☐ Buriel 2 XX Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specia		20b. Plece of I cemetery Metro	Crema	atory,	Inc.	1/28	/98	Balti	more,	MD
permit. Pages 1 el Depertment of Hea Important: If Itam any injury or othe		21. Signetura of Funeval Service Lice	· Mc None	ald	Cre	me and Add	ress of Fecility	ciety	of Ma	aryla	nd, I	nc.
Physician		23a. Part1. Enter the disease, or com shock, or heert feilure. List only	one ceuse on each line	Э.	ot anter th	e mode of dy		ardiac or rasp	iratory arras	t,	A In	ID 21228 pproximete itervel Between insat end Death
/Medical Examiner		Immediate Cause (Final disaase or condition resulting in deeth)	e. Fail	eine Due to (or es a co	onsequan	ce of):	Rive		0			year
be executed sician and buriel-transit	Examiner	Sequentially list conditions,		TO S To			Brea	st	AN	CRA		1772
# F #	Medical Ex	Sequentielly list conditions, if eny, leeding to immediata ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest	c	ua to (or as a co	onsequenc	ce of):						
0 2 9			d									
the e	Physician	Pert II. Other eignificent conditione of	contributing to death but	not resulting in	the under	lying ceuse g	iven in Pert I.	2	3b. Did tobe	cco use co	ntribute to th	ne cause of death?
requires that the death been signed by the etter hould be detached for u	by Ph	CDFD,	previou	15 S	Mo	Ku	g.		1 🗆 Yes	2□ No	3 Probat	bly 4 Unknow
2 S	Completed						0	2	4a. Wes en e performe		eveile	eutopsy findings able prior to pletion of ceusa eth?
	COL								1 🗆 Yes	2 No	1 D Y	res 2□ No
	Be (25. Was cese referred to medicel exeminer?					26. Plece	of Deeth (Che	ck only one)			
5 0 0	To	1 Yas 2 No	Hospitel: 1 Inpatian	t 2 ER/Outp	petient 3	DOA O	ther: 4 Nurs	sing Homa	i □ Residen	ce 6 □Oth	er (Specify)	
After fune		27. Manner of Deeth 1/2 Naturel 5 ☐ Pending 2 ☐ Accident investigatio	28e. Dete of Injury (Month, Day	Year) 28b. Ti	jury	28c. Inj W	ury et ork? ☐ Yes 2 ☐ N		escribe how	injury occur	red	
or Attendent effector: d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injur building, etc.	y - At home, fam (Specify)	m, street,	fectory, office	e	28f. Lc	ocation (Stre ity or Town,	et end Numt Stete)	per or Rural F	Route Number,
To the Hospital or Attent within 24 hours effect deef To the Funeral Director: completely filled in by the	edical (29a. Certifier (Check only one) Certifying Pt	nysicien: To the best of miner: On the basis of e	examination end	death oco /or investi	curred et the gation, in my	time, dete end opinion, death	plece, end du occurred et t	e to the ceu he time, date	se(s) end me e end place,	enner es stete end due to th	ed. e ceuse(s)
within 2 To the comple	Me	29b. Signature end title of certifier				29c. Licer	nse number		290	l. Date signe	d (Month, De	y, Year)
NHI		> Rule 11 1	Well al a.	bat		0	2/57	2.0	J	Horua	R4 2:	7,1998
De		30. Name and eddress of person who	completed cause of de	eth (Item 23e) (T	Type, Prin	1)	0. 4	1 0	11.	11 1	1 3	7,1998
8		HOLDDRUBET	7257	Old.	Au	napo	tes Re	2.61	1100	+ Cu	ty N	10
St Regis	tate trar	31. Dete filed (Month, Day, Year)	32. Registrer	s Signature	-Rand	A PO .					/	



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Hours

	1. Decedent's Name (First, Middle, Last)
Physician	ZeeBree
/Medical	4e Fecility Name (If not institution, give s

Directo

Funerai

à

Completed

Be

Physician/Medical Examiner

þ

Completed page 2 should

Be

To

Certification:

edicai

ZEEBREE MOLLEN

ZeeBree Ezell Britt-Mollon cility Name (If not institution, give street end number)

1□ M 2□XF

2. Dete of Death Month JAN. 26, 1998 3. Time of Death 1759 PM

5. Sociel Security Number

224-19-9144

PENINSULA REGIONAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthdey)

Yrs.

4b. City, Town, or Location of Deeth SALISBURY

WICOMICO 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country)

4c. County of Deeth

OCT 06, 1975 Washington, DC

10g. Citizen of What Country? USA

Funeral Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiana. Important: If Item 27 is marked other than "naturel", or Items 23e or 28a-1 show with Injury or other treumatic event, the Maxical Evantine: must be nortified and once.

Baltimore, Maryland 21215-0020

Usuel Residence of Decedent 10e. State MD

10e. Street end Number 605 Dwyer Place 11. Meritel Status

10b. County Prince Georges 10c. City, Town or Location Upper Marlboro

10f. Zip Code

Deys

10d. Inside City Limits 1 ☐ Yes X☐ No

1 Never Married 2 Merried 3 Widowed 4 Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes:

 Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2√ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12)

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

20774

16b. Kind of Business/Industry

17. Fether's Neme (First, Middle, Last)

Student

College 18. Mother's Name (First, Middle, Maiden Sumeme)

Robert J. Britt 19a. Intorment's Neme/Relationship (Type, Print)

Joan Webster 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)

Mark V. Mollon/husband

1208 Heritage Hills Dr. 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) Date

Upper Marlboro, MD20772 20c. Location - City or Town, State

20e. Method of Disposition

1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel trom Stete 4 ☐ Donetion 5 ☐ Other (Specify)

Metro Crematory, Inc. 01/29/98

Baltimore, MD

21. Signeture of Fune al Service Licenses

Dawn F. McDonald

22. Name end Address of Fecility
Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

ettending physician end for use as the buriel-transit certificate be exacuted

signed by the e

certificata has

this funeral

tha

filled in by

after death.

24 hours

To the Hosp within 24 hor To the Fune complately fi

Box 68760.

Division of Vital Records,

Hospital or Attending Physician:

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last

Immediate Cause (Final disease or condition resulting In deeth)

Multiple Dyurie Due to (or es e consequence ot):

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line.

Due to (or es e consequence of):

Due to (or es e consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco usa contributa to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Wes en eutopsy performed?

24b. Were autopsy findings eveileble prior to completion of cause ot death?

Approximete Intervel Between Onset end Deeth

1 Tes 2 □ No

26. Place of Deeth (Check only one)

25. Wes case reterred to medicel exeminer? iXDVes 2□ No

27 Manner of Death 5 Pending investigation 28e. Date of Injury (Month, Day Year) 1-26-98

Hospital: 1 ☐ Inpatient 2 X ER/Outpetient 3 ☐ DOA 28b. Time of Injury 1734 PM

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred pedestrian struck by car

6 Could not be determined

28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28t. Location (Street end Number or Rural Route Number, City or Jown, Stete) R + 13

28t. Location (Street end Number or Rural Route Number)

28t. Location (Street end Number or Rural Route Number)

28t. Location (Street end Number or Rural Route Number)

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28t. Location (Street end Number or Rural Route Number)

28t. Location (Street end Number or Rural Route Number)

28t. Location (Street end Number or Rural Route Number)

28t. Location (Street end Number or Rural Route Number) 6 Could not be determined 4 | Homicide

(Check only one) 29b. Signeture end title of certifier

Dennis

1 Naturel

2 Accident

3 Suicide

29e. Certifier

MCMedical Examinar: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E

JAN. 27, 1998

5 Chuto is 30. Neme and eddress of persop who completed cause of deeth (Item 23e) (Type, Print)

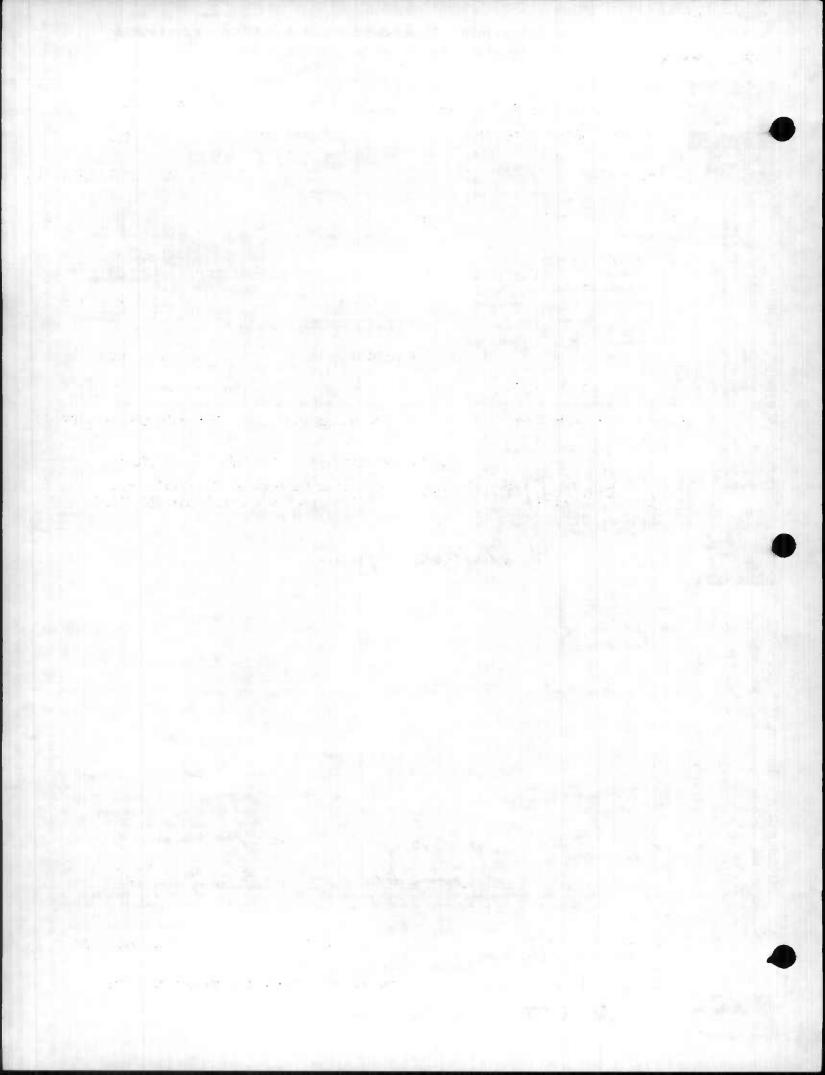
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111 Penn Street, Baltimore, Maryland 21201

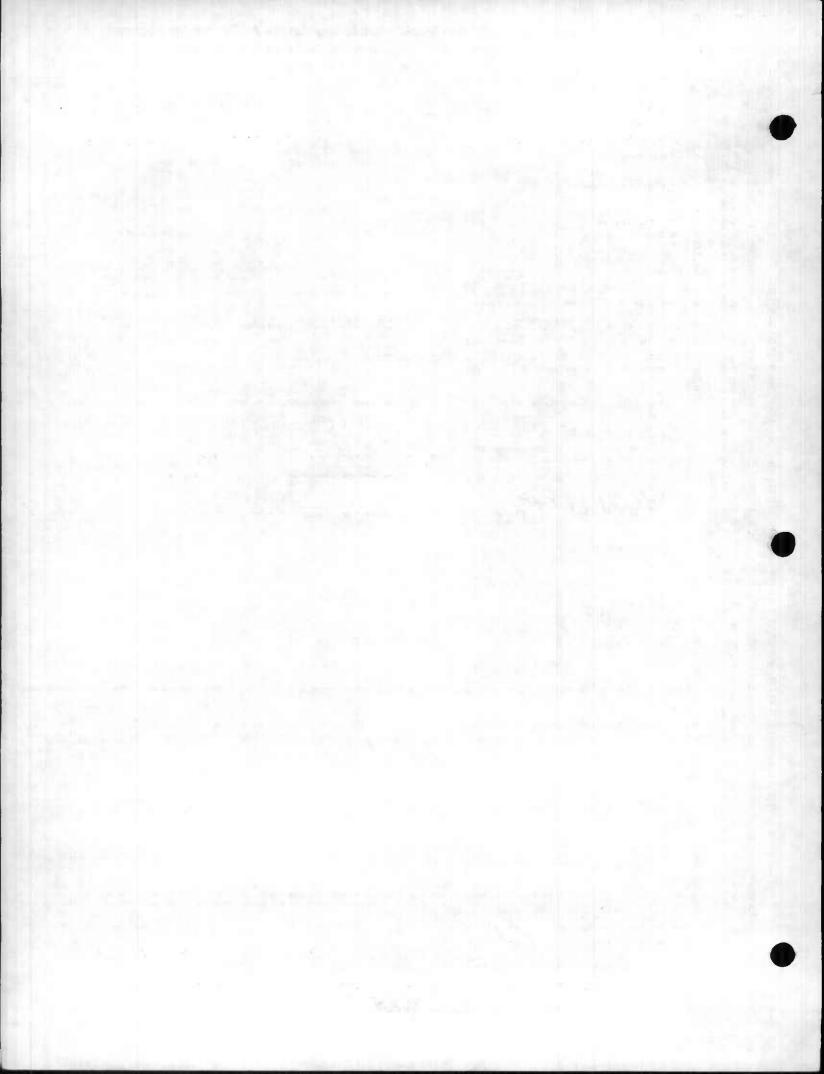
State Registrar

31. Dete tiled (Month, Day, Year) JAN 3 0 1998

Chute, mo 32. Registrer's Signature Julia Davidson - Mandall

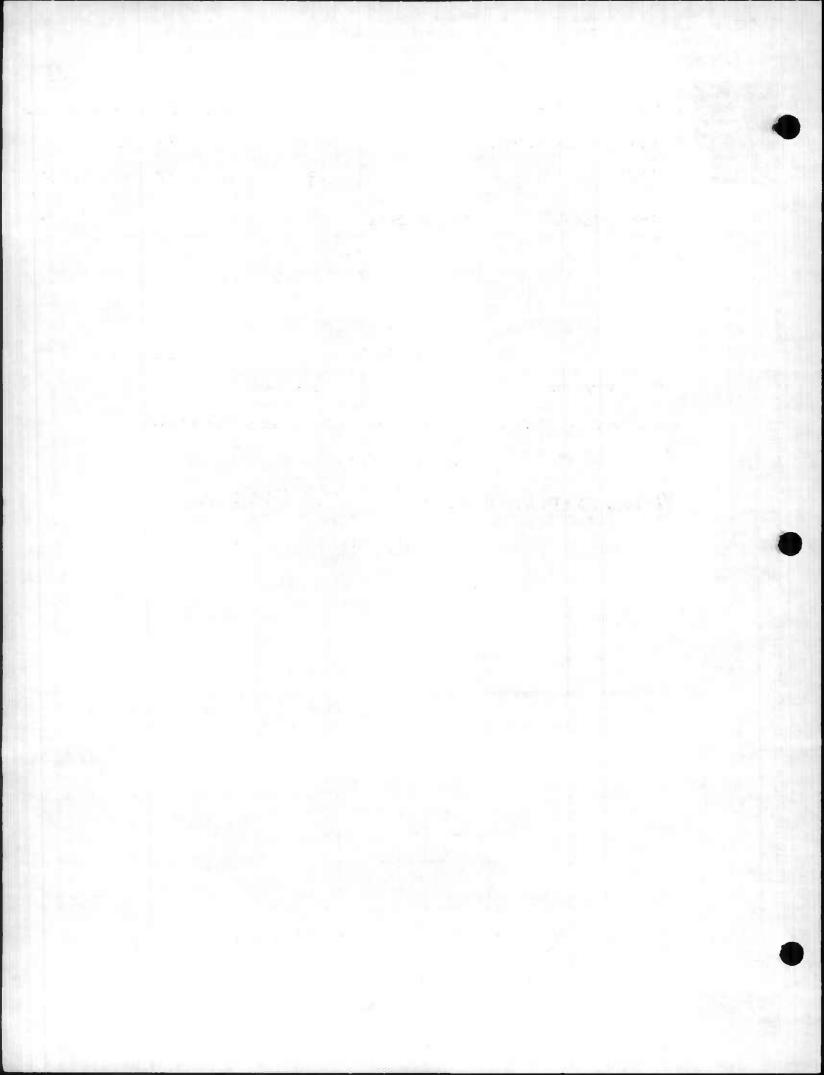


AKISHA BAK Items:23a nar	ER t I,27 per MEO G-756 2/	State of M	aryland	-			eaith a Death		ental Hy	giene Reg. No.	8	023	84
Physician	Decedent's Name (First, Middle, Last LAKISHA								2. Date of De Month JANUAF	eath Day	Yea 1998	ır	me of Death
/Medical Examiner	4a Fecility Neme (If not institution, give					4	b. City, To	wn, or Lo	cation of Deet		ounty of De		JO F
	NORTH ARUNDEL HOS	PITAL				(GLEN I	BURN:	IE	ANN	E ARU		
Funeral Director	5. Social Security Number 6. S 212-86-8700	ex	e (In yrs. les 3	st birthdey) Yrs.	If Und Months	Days	If Under Hours	24 Hrs. Min.	8. Dete of Bir Manth, Di JAN 3	1, 1974	9. E BAI	Birthplece (S Country) LTIMOF	RE, MD.
pud *	Usual Residence of Decedent 10e, Stete 10b, County		10c City	Town or Loc	cation							10d ins	Ide City Limits
offer death with the Marylan retires 23s or 28s-f show retires must be notified at Funeral Director	MARYLAND ANNE ARU	NDEL CO.	MAGC			0-4-				10- 02	4 1475	X	Yes 2□No
with the sort	10e. Sfreef end Number	DOAD				ip Code					n of Whet	Country	
ns 23a	61 MAGOTHY BEACH	12. Wes Decedent	Ever in U.S.	13. V		122 edent of H	ispenic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	USA - 14	. Raca - Ar	merican Indi	an,
by	1 💢 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:				V	Specify:	i, Puerto	Rican, etc.)		Black, Wi pecify: A		MERICAN
ed within 72 hours ygiena. her than "natural", rt, the Medical Eva Completed by	15. Decedent's Ed			16e. Deced	enf's Us	ual Occup	ation during mos	t of worki	na	16b. Kind	of Busine	ss/Industry	
5 5	(Specify only highest gra	College (1-4or	5+)	life. D	O NOT	use retired)	(Or WORK	ng .			•••	
Hygier ther the ont, in	12			CL	ERK	-	to Marke	ula Manua	(Final Baintalia		ARGET	CO.	
Mental Mental arked of artic events	17. Fether's Name (First, Middle, Lest) ALVIN BAKER SR.						i.IN	IDA	(First, Middle				
12 sho h and r is me	19a. Informant's Name/Relationship (7					1.610.00			A CDENA				
s 1 and of Health Rem 27 other tr	ALVIN BAKER SR. F	ATHER	20b. Plac	61 MA ce of Dispos netery, crem				D, P	ASDENA		-	or Town, St	ate
emil. Pages 1 a Department of Hee mportant: If Item my Injury or othe	1 □XBurial 2 □ Cremetion 3 □		4										
	4 ☐ Donetion 5 ☐ Other (Specif) 21. Signature of Funeral Service Licen		MI.	ZION					/29/98			MARYLA	עאוּ
permit. Departuimporta any inje	LLOYD M. ESI								RAL HO			ND 212	217
Physician	23a. Part1. Ent. III disease, or comp shock, or heart failure. List only	plications thet cause one ceuse on each li	the death.					-				Appro	eximete al Between and Death
/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	a. CARDIAC		HMIA as e conseq	uence of):							
in d		MULTIPL											
ate be executed hysician and the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	0.	Due to (or a	is e conseq	uence of):							
be experient burie	Causa (Disease or injury	c								- 1-1-		i	
	that initiated events resulting in death) Last	d	Due to (or e	s a consequ	uence of	:							
death e etter ad for u	Part II. Other significent conditions or	natribution to double	ut not require	ing in the up	doduine	cauca ciu	on in Bort i		23h Did	tohacco u	ee contrib	ute to the c	ause of death?
that the ed by the detache	ratti. Otto signitioni conditions a	Simboling to death b	ot not result	ing in the di	luottyiilig	cause giv	6111111111111						45/Unknown
The law requires that atta has been signed to page 2 should be det.									24e. Wes	s en eutops ormed?	y 24	evailable	on of cause
The law page 2									XX	Yes 2	No	₹ Q{Yes	2 No
ysiclen: The scerificate director, pag	25. Wes case referred to medical						26. Plece	of Death	(Check only	one)			
Z 0 0	examiner? 1XXYes 2 □ No	Hospital: 1 ☐ Inpati		R/Outpatien	f 3□ [Oth Oth	er: 4 🗆 No	ursing Ho	me 5 Res	idence 6	Other (S	Specify)	
Attending Ph or deeth. Sctor: After thi by the funeral	27. Manner of Deeth 1 CNeturel 5 Pending 2 Accident investigation		ry y Year) 2	8b. Time of Injury	М	28c. Injur Wor 1	yat k? Yes 2□		28d. Describe	how Injury	occurred		
tal or Attending P rs after deeth. at Director: After t led in by the funeri Certification:	3 ☐ Suicide 6 ☐ Could not be determined	288. Placa of th	ury - At hom c. (Specify)	e, ferm, stre	et, facto	ery, office			28f. Location City or To	(Street and own, Stete)	Number or	Rural Rout	e Number,
Hospi 24 hour Funer tely fill		ysician: To the best niner: On the basis of and marines at											ause(s)
within 2 To the compla	29b. Signature end fitle of certifier	OFF			2	9c. Licens						onth, Day, Y	'ear)
	30. Name and address of person who	Completed serves	looth (Itam 0	(2a) /Tuna	Print	001	1E			JANUA	RY 23	1998	
	David Fowler, M. I					imore	e, Ma	rylar	nd_2120)1			



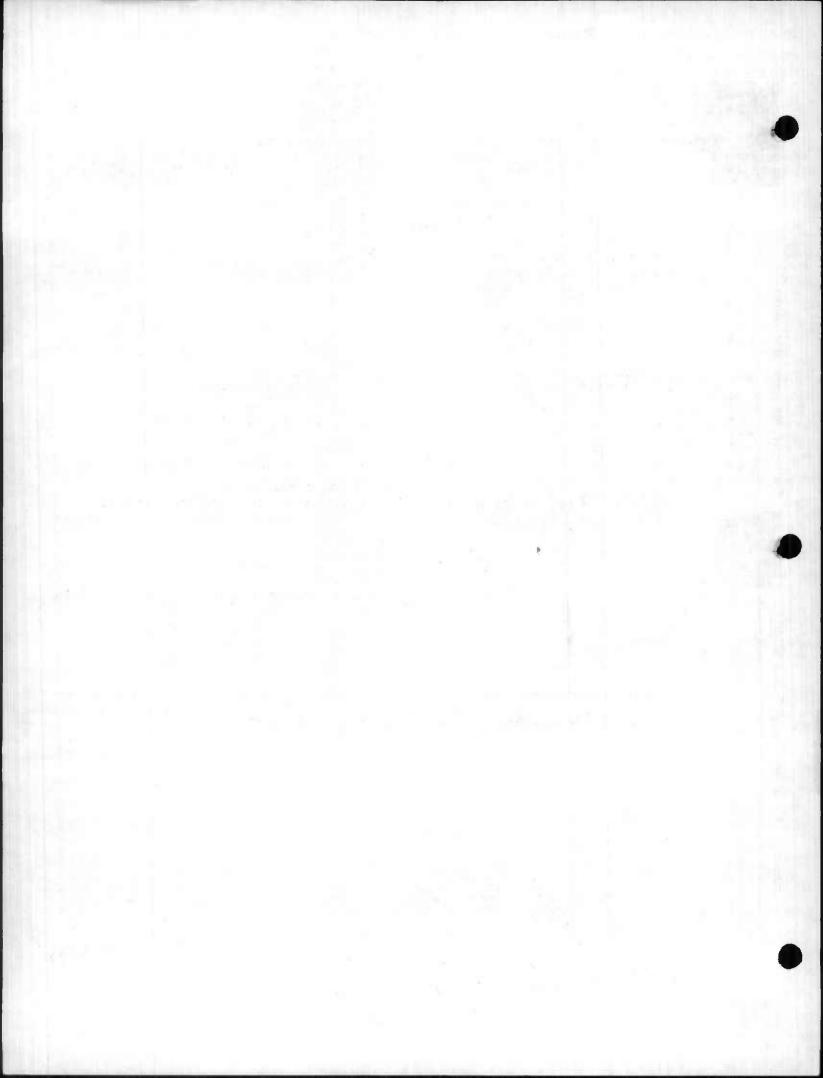
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Nema (First, M.	iddle, Last)			ertificate of		2. Date of Deat			ime of Death
Physic		Isabel Freida	Rishon					Januar	Dey 27, 1	Yeer 1998 9	11 A.M
/Medi Examii		4e. Facility Neme (If not institu		number)			4b. City, Town, or Lo		4c. County		TT V.()
Exami		Franklin Square	Hospital Cer	nter			Rosedale		Balti	morre	
Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. lest birthday	If Undar 1 Year	If Under 24 Hrs.	8. Data of Birth		9. Birthplaca (S Country)	State or Forei
Director		215–10–7514 Usuel Residence of Decedent	1□ M 2√ F	77	Yrs.	Months Deys	Hours Min.	(Month, Dey, March 26		Baltimore	,Maryla
yland		10a. State 10b. Cou	inty	10c. (City, Town or L	ocation					ide City Limi
death with the Maryland ms 23a or 28a-1 show	ctor	Maryland Balti	imore	Balt	timore Co	ounty				1	Yes 2 N
or 28	ire	10e. Street and Number				10f. Zip Code		10	g. Citizen of	What Country?	
th wi	aj [c	6224 Ebenezer Ro	oad			21220		l	JSA		
or its	y Funeral Director	11. Marital Status 1 ☐ Nevar Married 2 □ X N	Armed 1 ☐ Ya If Yes,	ecedent Ever in Forces? Is 2 No Give	U,S. 13.	. Was Decedant of H If Yes, specify Cub. 1 ☐ Yes 2 ☑ No	lispanic Origin? (Span, Mexicen, Puarto Specify:	ecify Yes or No- Rican, etc.)		ce - Americen Indi ck, White, etc.	ien,
"natural",	d by	3 Widowed 4 Divor	ced Year o	r Dates:	10- D-	1 11 10				White	
- 2	Completed	(Spacify only hig	dent's Educetion ghast grade complete	ed)	16a. Deci	edent's Usual Occup e kind of work done	petion during most of work d)	ing	6b. Kind of B	usiness/Industry	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Magones.	шс	Elementary/Secondary (0-1:		e (1-4or 5+) /A		Bus Driver	,		Raltimon	e County	
Hyg Hyg ant,		17. Fathar's Nama (First, Midd			OCI DOIL	DOS DITVOI	18. Mother's Name				
ental ental ked c	To Be	Frederick Henry	Porter				Lena Stumpf				
meri meri	-	19e, Informant's Name/Relation			19b. Mai	ling Address (Street	end Number or Run		City or Town.	Stete, Zip Code))
27 is		John J. Bishop,		d)			ed Baltimor				
f Hear term other		20a. Method of Disposition	CE 1 (11000CI II	*		position (Name of ematory or other pla		-		- City or Town, Ste	ete
ant of		1X Burial 2 ☐ Crematic 4 ☐ Donetion 5 ☐ Other		m State			January 30,	1998 B	altimore	, Maryland	1
Departmy Importan any injur		21. Signeture of Funeral Serv				22. Name end Addre		1000	TOTING	, ranyauro	
Physician /Medical Examiner		23a. Pert1. Enter the disease shock, or heart feilure. I Immediete Ceusa (Final disease or condition resulting in deeth)	θ		ath. Do not e	nter the mode of dyin	Road Balting, such es cardiac de Portian	or respiretory erre	st,	Appro Interv Onset	el Between t end Deeth
g iš	iner		- CU	Monic	Oles	huch've	Pulmor	on dz.	exacer	betign -	200
execute in and iel-trans	Examiner	Sequentially list conditions, if eny, leeding to immadiate ceuse. Enter Undarlying Cause (Diseese or injury		Dua to	(or es e conse	equence of):					
ertificate be executed ding physician and se es the buriel-transit	Medical	Cause (Diseese or injury that initiated events resulting in death) Last	c	Dua to	(or as a conse	equence of):					
ettendin d for use	ician	Pert It. Other eignificent cond	ditions contributing to	dooth but not w	noutting in the	undadulas aguas sis	roe in Post I	22h Did to	2000 1100 000	entribute to the ca	auga of do
ires thet the death cer signed by the ettendin d be detached for use	Physician/N	CHF	1	ener		1 2 mil		1 Ye	•	3 Probably	
requiper shoul	Completed by							24e. Was ar	autopsy ed?	24b. Were eut eveileble completio of death?	prior to on of cause
ate h	COL							1□ Ye	s 2010	1 ☐ Yes	21 No
ctor,	Be (25. Wes cese referred to med examiner?					26. Plece of Deet	h (Check only on)		
this certific ral director,	10	1 ☐ Yes 2 No	Hospital:	Inpatiant 2	☐ ER/Outpatie		4 LI Nursing Ho	me 5 Reside	nce 6 □Oth	ner (Specify)	
within 24 hours effer death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicida 6 ☐ Cou	estigation uld not be ermined 28e. Pla	te of Injury lonth, Dey Year) ace of Injury - At ilding, etc. (Spec	home, farm, s	Wo	Yes 2 □ No	28d. Describe ho 28f. Location (Str City or Town	eet end Numi	rred ber or Rural Route	e <i>Nu</i> m <i>ber</i> ,
24 hours Funeral letely filled	Medical Co	29a. Certifier (Check only one) Certifier 2 Medic	fying Phyelcian: To the cat Examiner: On the end m	the best of my ki basis of examination	nowledge, dee nation and/or i	th occurred et the tin nvestigation, in my o	me, dete end plece, opinion, death occurr	end due to the ce red at the time, da	use(s) end mete and place,	enner as steted. and due to the ca	ause(s)
Withir Comp	Me	29b. Signeture end title of cert	- 1	ee N	10.	29c. Licens	- 38 7 5	4 25	d. Date signe	7-98	(eer)
7.											
14.		30. Neme end address of pers	BROAD			HLTIMORI	e . MD- 2	21231.	MAL	IKA WI	ASERI



State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, M.	tiddle 1 s	pet)		Ce	ertificate o	f Death	2. Dete of De	Reg. No.	0	2386
Physic		Evelyn B. Bennet		131/						29, Day 1998	Yeer	12:04 a.m.
/Medi		4e. Fecility Neme (If not instit		re street end nu	mber)			4b. City. Town. o	r Location of Deeth		of Deeth	12.04 d.III.
į Examir	ier	Carroll Lutheran	_					Westminst		Carro		
Funeral Director		5. Social Security Number 220–03–1825		Sex 1□M 2□F	7. Age (In) 86	rrs. last birthday Yrs.	Months Dey			1911	1 COUR	piece (Stete or Foreign ntry) more Co., Md.
and and		Usuel Residence of Deceder 10a. Stete 10b. Co.			10c.	City, Town or I	ocation				1	10d. Inside City Limits
the Marylan r 28a-f show	tor	Maryland Carro	11		W	estminste	err					1 ☐ Yes 2 ☐ No
or 28s	irec	10e. Street end Number				0001111100	10f. Zip Code			10g. Citizen of	Whet Cour	ntry?
23a c	rai	205 St. Mark Way	Apar	rtment 50	5		21157			USA		
72 hours after death with the Maryland natural, or tlems 23a or 28a-f show dical Examinal must be notified at	by Funeral Directo	11. Marital Status 1 Never Married 2		12. Was Deci Armed Fo 1 Yes If Yes, Gir Yeer or D	rces? 2 🔀 No /e	n U,S. 13	. Was Decedent of If Yes, specify Cu	Hispenic Orlgin? uban, Mexican, Pue o Specify:	(Specify Yes or No arto Rican, etc.)	14. Rad Ble Specif	ck, White,	
id 2 should be filled within 72 hours af this and Mental Hygiens 17 Is marked other than "natural", or traumatic event, the Medical Examp	Completed	15. Dece (Specify only hi	dent's E	ducation ade completed)		16e. Dec	edent's Usuel Occ e kind of work don	upation e during most of w	orkina	16b. Kind of B	usiness/In	dustry
d within plene. r then "	mpi	Elementary/Secondery (0-		College (1-4or 5+)	Cleric		e during most of w red)		Stowart !	Dona	rtment Store
e filed withing Hygiene. other then	ပ္	17. Fether's Neme (First, Mid	die, Last		1	Cleric	aT	18. Mother's N	ame (First, Middle,			rule ic state
Mental Mental arked o	To Be	Charles Burkhard							Schneider		,	
d 2 should be filed the end Mental Hyg 7 Is marked other traumatic event,	-	19a. Informent's Name/Relat	ionship (Type, Print)		19b. Mel	ling Address (Stre	et end Number or I	Rural Route Number	er, City or Town	, State, Zip	Code)
		Frank Mitchell						Reisters	town, Mary]	land 21136	3	
S = 0		20e. Method of Disposition	on 3 [Removal from	State 20	 b. Place of Disp cemetery, cr 	oosition (Neme of emetory or other p	lace)	Date	20c. Location	- City or To	wn, State
permit. Page Depertment of Important: If any Injury or		4 □ Donetion 5 □ Othe 21. Signature of Funerel Sen	r (Specif	y)				January 30	-	Baltimore	e, Mary	yland
bemit. F Depertme importan importan any injur		23e. Pert1. Enter the disease shock, or heart failure.	6 or com List only	plications thet cone ceuse on e	aused the dach line.	oki 7	401 Belair	ress of Facility Neral Home, Poad Balt: Ying, such es cardi	imore, Mary		36-462	Approximete Intervel Between Onset end Death
/Medical Examiner		Immediate Ceuse (Finel disease or condition resulting in death)		e. Se	PSUS	o (or es e conse	equence of):					Ide
tificata be axecuted og physician and as the buriel-transit	Aedical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	{	b. Re		o (or es e conse		s worth	Hyroso	u	-	Idea
- D 0	Physician/Medi	resulting in deeth) Lest Pert II. Other eignificant con-	L	d.					ant Bliv			
d by th	by Phys	Mixed							40	Yes 2KNo		o the cause of death: bably 4 Unknow
2 s S	Completed						. 0			en eutopsy rmed?	ev	ere eutopsy findings elleble prior to impletion of cause deeth?
E 2 0	Cou								1 🗆 1	Yes 2000	1[☐ Yes 2☐ No
Physician: The	Be	25. Wes case referred to med exeminer?	lical	Hospital:				M4	eeth (Check only o			
S S D	ation: To	1 Yes No 27. Menner of Deeth Naturel 5 Pe 2 Accident Inv	nding estigation	28e. Dete		28b. Time Injury	of 28c. In		Home 5 Resid	dence 6 Doth		y)
To the Hospital or Attending Phwithin 24 hours eftar daath. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide	uld not be ermined	20e. Piece	of Injury - Ang, etc. (Spe	t home, ferm, s ecify)	treet, factory, offic	a	28f. Location (S City or Tox		ber or Rura	al Route Number,
Hospi 24 hou Funer tely fill	Medicai	29a, Certifier Check only 2 Medi	fying Pir cel Eynin	ywylen: To the	best of my lasis of exam	howledge, dee ipation and/or i	th occurred et the	time, date end place opinion, death occ	ce, end due to the curred et the time,	ceuse(s) end m date end pleca,	enner es s	teted. the ceuse(s)
thin 2 the omple	Med	29b. Signature and title of cer	-(//	and man	ner stated	/	1	nse nu <i>m</i> ber		29d. Date signe		
F * F 8		•	/	1	1		250. 2706					
DK.		30. With and address	now who	company can	e of cheate.	23a) (Type	Print)	37949		Jan	297	ग ।५५४
φ		1425 Where	138	o Su	were of	3208		ushun	un.	QU	184	h lags
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State of Maryland / Department of Health and Mental Hygiene

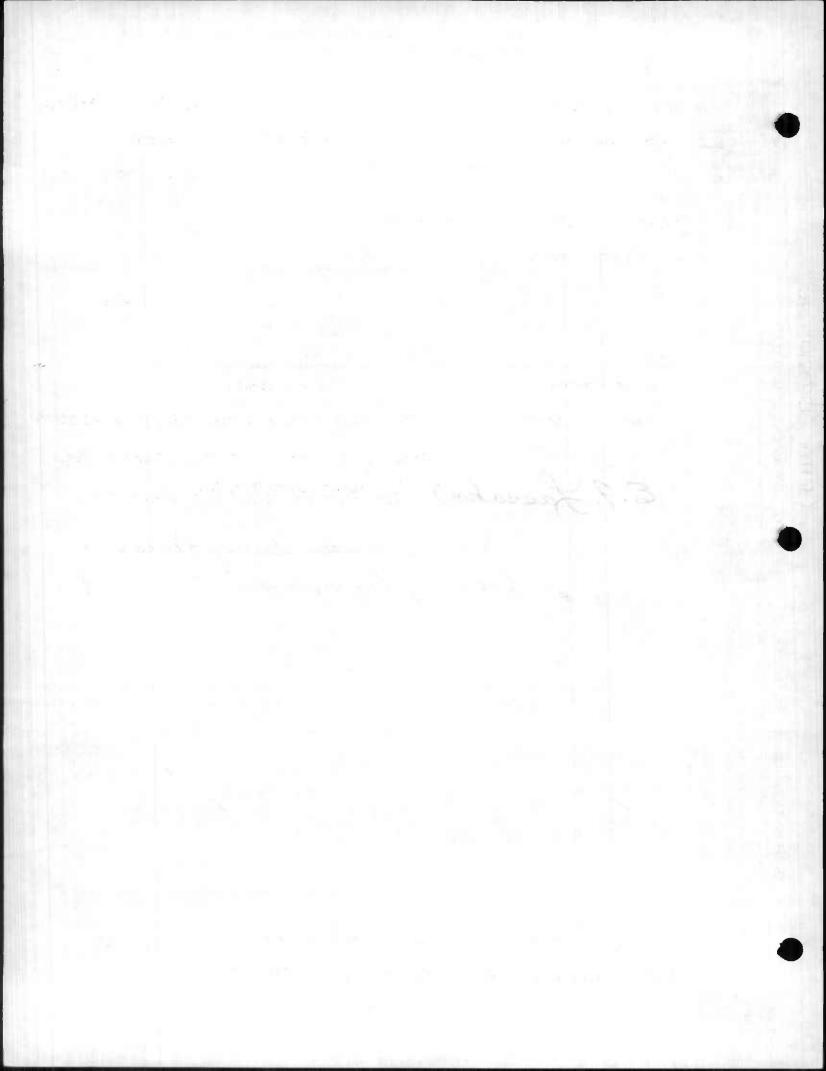
Certificate of Death

Reg No. 9 8 1238

						Ce	rtificate	of	Death			Reg. No.	5 U	2301
5 1		1. Decedent's Name (First, M	iddle, Las	it)							2. Date of De	ath	Year	3. Time of Death
Physician /Medical		Arthur Joh	n B	rockme	eyer						January	28, Dey 1998	3	8:00 a.m.
Examiner	-	4a. Facility Neme (If not institu			4				4b. City, To	wn, or Lo	cation of Deet		ty of Death	
Examine		2000 Tiffany T	errac	e				F	orest	Hill		Harfo	hrrd	
Funeral		5. Social Security Number	6. S		7. Age (In yr	s. last birthday	If Under 1	Year	If Under		8. Date of Bir	th		plece (State or Foreigntry)
Director		214-16-6389 Usual Residence of Decedent		M 2□ F	75	Yrs.	Months	Days	Hours	Min.	Nov.30	y, Year)	Perry	y Hall,Md
illed within 12 hours eiter death with the Maryland Hydiene. Hot than "naturel", or Items 23e or 28e-f show hit, the Modical Examinat must be notified at		10a. State 10b. Cou	nty		10c. (City, Town or L	ocation							10d. Inside City Limit
to Tot	2	Maryland Har	ford		Ec	rest H								1☐Yes 2🕅 N
or 28a-f show a notified at Director	3	10e. Street and Number	TOTU		110	1636 11.	10f. Zip C	ode			T	10g. Citizen o	I What Cou	ntry?
r Items 23e or 28e-fs	5	2000 Tiffany	Terr	ace			210	50				U.S.A		,
hems 2	0	11. Marital Status	. 011		edent Ever in orces?	U,S. 13.			lispanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)		ace - Ameri	
0 5		1 Never Married 2 N N		1 XYes	orces? 2 No 1/1 Dates: 1/11	6//3	If Yes, specify 1 ☐ Yes 2 €				Rican, etc.)	Spec	lack, White, lify: Whit	
"naturel",	3	15. Dece	dent's Ed		1/11		dent's Usual	Occur	nation			16b. Kind of		
		(Specify only high	phest gra	de compieted)		(Give	kind of work DO NOT use	done	during mos	t of worki	ing	TOD, KING OF	DUSINGSSAIN	idustry
event, the Menor Second		Elementary/Secondary (0-1	2)		1-4or 5+)							0 36 5		1
s marked other than aumatic event, tha M To Be Comr	3	17. Father's Name (First, Mide	to I got)	n/a		Newsp	aper C	arı		ada Nama	(First, Middle	Self-E		ea
Se e												INIGIOGII SUITI	ame)	
T Etc	2	Joseph Brock							Agnes					
aun aun		19a. Informant's Name/Relati				19b. Maili	ing Address (Street	and Numb	er or Rura	al Route Numb	er, City or Tow	n, State, Zij	Code)
Important: if Item 27 is marked other any Injury or other traumatic event, ii once. To Be Co		Mrs.Marie A.E	Brock	meyer	(Wife)	2000	Tiffa	ny	Terra	се	Forest	Hill,	Maryl	and 21050
a de		20a. Method of Disposition	-			Placa of Dispersion of Dispers	osition (Neme	of er pla	ca)		Date	20c. Location	- City or To	own, State
7 0 1	4	1 ☑ Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Other				oreland				. 1	/31/08	Rol+im	ore M	d.21234
2	-	21. Signeture of Funeral Serv			200		2. Name and				731730	Datetii	1016,11	0.21254
S S		= 1	1	/	1	N. C. C.				*	ome, P.A			
	1	6.7.	74	rssi	ense	/ 1	1/50 Be.	lair	Road	Kin	gsville,	Maryland	21087	-1351
	1	23a. Pert1. Enter the disease shock, or heart failure.	or comp	olications that one ceuse on o	caused the de sech line.	ath. Do not en	ter the mode	ol dyir	ng, such as	cardiac c	or respiratory a	rrest,	1	Approximete Interval Between
sician	1				0.	. 1				0	•	1		Onset and Death
ledical	1	Immediate Cause (Final disease or condition			Arm	er ll	boker	de	me (1120	rano	X) in	esse	5
miner	1	resulting in death)		a	Dunto	ie A (or as a conse	cuonos of)		<i>>></i>	con		10,00		J
	5			P	Due 10	(OI as a COIISE	querice Di).		-:00	1			4.	4
buriel-transit				b. /				er	gice	asi	2		-	/
is the buriel-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			Due to	(or as acconse	quence (N):	4	/				1	
burie Burie	5	Cause (Disease or injury	2	c										
9 2 S	3	resulting in death) Lest			Due lo	(or as a consec	quenca of):							
2 0 2			L	d									ì	
eteched for us Physician/	5			u									İ	
sici	5	Pert II. Other significant cond	litions co	ntributing to d	eath but not re	sulting in the u	inderlying cau	se giv	en in Part I	l.	23b. Dld	tobacco use o	ontribute t	o the cause of deat
detech Phy											10	Yes 2□ No	3 □ Pro	bably 4 Unkno
be de											100			
should b											24a. Was	en eutopsy	24b. W	ere autopsy lindings
short short											perfo	rmed?	CC	reileble prior to empletion of cause
N Q	1											1	ol	death?
Com	3										10	Yes 20 No	1	☐ Yes 2☐ No
Be Co	3	25. Was case referred to med examiner?	ical						26. Place	of Death	(Check only	one)		
To B		1 Yes 2 No		Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Oth	ner: 4□ Nu	ursing Ho	me 5 Resi	denca 6 🗆 C	ther (Speci	fy)
		27. Manner of Death		28a. Date	of Injury th, Dey Year)	28b. Time o	of 280	. Injui	ry et		28d. Describe	how injury occ	urred	
fune		1 ØNatural 5 ☐ Per 2 ☐ Accident inve	iding estigation		in, Dey Tear)	Injury	М		Yes 2	No				
d in by the	2	3 ☐ Suicide 6 ☐ Cor	ild not be	28e Place	of Injury - At	home, farm, st	reet factory	office			28f. Location (Street and Nur	nber or Run	a / Route Number,
led in by the funeral Certification:		4 Homicide	ermined	build	ing, etc. (Spec	cify)	root, ractory, t	311100			City or To			
D 0	5													
completely filled in	3			Iner: On the b	asis of examin	nowledge, deat nation and/or in								
aple Med	3	7.11.4		and man	ner stated.									
000		29b. Signature and title of oar	ther /		,				se number			29d. Date sign	ned (Month,	Day, Year)
		1 Amer	1	unt	un	MD.	D	3	366	27		1-2	8-95	?
1	1	30. Neme end address of pers	on who	ompleted caus	se of death (It	em 23a) (Type	Print)		- > -		/	, ,,,	/0	
1		615 W. M	ne F	Phail	Ra.	10. em 23a) (Type,	Air.	m	02	-101	7			
Chah		31. Date filed (Month, Day, Ye		32 F	Mhistrar's Sin	lature			-		/			
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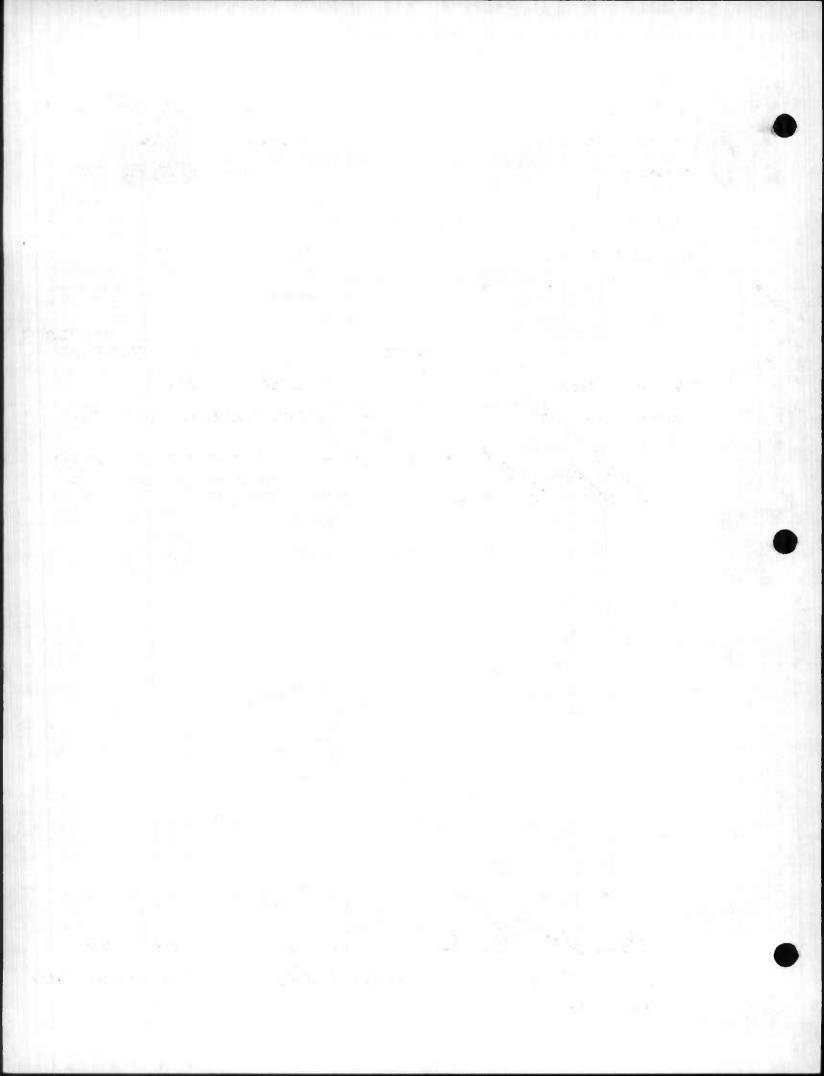
DHMH 16 Rev 6/95

arthur Brockmeyer



State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate	of	Death			Reg. No.	98		238	8
	Dhuniai		1. Decedant's Nama (First, Middle, La	ist)			-				2. Data of Dea	ath Day		201	3. Tima o	Death
	Physici /Medi		CHARLES W. BOWMAN								JANUAR		, 199	aar 8	7:15	AM
	Examir		4a. Facility Nama (If not institution, gir	e street and number))				4b. City, To	wn, or L	ocation of Death	4c.	County of	Death		
			635 NORTH BEND RO						BALTI				LTIMO			
	Funeral Director			M SUE	ga (In yrs. last i 31	birthday) Yrs.	If Undar 1 Months I	Yaar Days	If Undar Hours	24 Hrs. Min.	8. Data of Birt (Month, Da APR • 1	y Year) 3, 1	916 V	. Birthpi Count IRG	aca (State of INIA	or Foreign
	yland		10a. Stata 10b. County		10c. City, To	own or Loc	cation							10	od. Insida C	ity Limits
	tar death with the Manylan Items 23a or 28a-f show Inst. must be nourfed at	Director	MARYLAND BALTIM	ORE	BALTI	MORE	10f, Zlp C	oda				10a Citis	zan of Wha	at Count	1 ☐ Yas	X No
	ath with		635 NORTH BEND RO	AD					21229				U.S.A			
020	ai', or	by Funeral	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Armed Forcas? 1 ☐ Yas 2 X If Yas, Giva Yaar or Datas:	?		Vas Decedar f Yas, specify I □ Yas 2)			gin? (Sp , Puarto	ecify Yas or No Rican, atc.)		14. Race - Black, ! Specify:	Whita, a	atc.	
5-0	n 72 hours "natural", bolical Exc	Completed	15. Decedant's E (Specify only highast gr		16	(Giva I	ient's Usual (kind of work	done	during most	of work	ing		nd of Busin		-	
121	d within piena. r than	idu	Elementery/Secondery (0-12)	Coilega (1-4or		life. D	OO NOT use	retire	od)						P BUI	
d 2	TO CO. be		17. Fathar's Nama (First, Middla, Last)	R	IGGE	K		18 Motha	r's Nam	a (First, Middla,			K U	OMPAN	Y
lan	S a b s	To Be	WILLIAM L. BOWMAN						10.		M. MCCA		Surrainer			
Maryland 21215-0020	2 she and and is much	1	19a. Informant's Name/Ralationship (RUTH A. BOWMAN, W	Type, Print)							ral Route Numbe					
re,	permit. Pages 1 and 3 Department of Haalth important: If item 27 i any injury or other tr. 90008.		20a. Mathod of Disposition	esta oued execut	20b. Placa	of Dispos	sition (Name	of		<u> </u>	Data		cation - Cit			
Baltimore,	Page nt: If iry or		1 ☑ Burial 2 ☐ Cregation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special				CEMET		•	1	/31/98	WOOD:	LAWN.	MAI	RYLAN	0
alti	Departm Departm mports any inju		21. Signature of Funeral Sende Lice	r500 //							ZKE FUN					
00	20158		> Michael	from	~	16	30 EDM	NON	DSON A	AVEN	UE, CAT	ONSV	ILLE,	MD	2122	8
			23a. Part 1. Entar tha disaasa, or com shock, or haart failura. List only	plications that cause ona causa on aach li	d tha daath. D	o not anta	ar tha moda	of dyi	ng, such as	cardiac	or raspiratory ar	rrest,			Approximet	a ween
S	Physician					1-	17								Onsat and	
1	/Medical Examiner		Immediata Causa (Final diseesa or condition resulting in deeth)	a. / / /	etuota	An	· Co	272	en					i		
		e.	Todaking in dodity		Due to (or as	a consequ	uence of):							1		
	uted	Examiner		b. ———	5 - 1 - 1 - 1		3 0							1		
Ć,	icate be executed physician and s the burial-transit	Exa	Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Diseasa or injury that initiated avants		Dua to (or es	a consequ	uanca of):							į		
68760,	ysicia	edicai	Causa (Diseasa or injury that initiated avants	C	Dua to (or as a	a consequ	uance of):									
k 68	The Dag	2	rasulting in death) Last		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	,							i		
Box		Physician/		d												
0	the dea by the a ached f	ysic	Part II. Other significant conditions		out not rasulting	in tha un	ndarlying cau	ısa gi	van in Part I.		23b. Dld t	obacco	use contri	bute to	the causa	of death?
0	that the sed by detac		renal fu	lue							10	Yes 2	No 3	Prob	ably 4	Unknown
of Vital Records,	v requiras been sign should be	Completed by									24a. Was perfo	an autop med?	sy 2	con	ra autopsy i ilable prior i nplation of c laath?	0
œ e	The lav	E O									101	ras 26	Z No	1 🗆	Yas 2□	No
Ita	ysician: The I s certificate he director, page	Be	25. Was case refarred to medical axaminar?					_	26. Plece	of Deet	h (Check only o	ne)				
1	Physician: r this certific tral director,	2	1 ☐ Yas 2 ☐/No	Hospital: 1 Inpatia		Outpatient				rsing Ho	ma 5 Design	dance 8	Othar (Specify)	
S L	or Attending Phattar death. Director: Aftar thi	ion:	27. Menner of Death 1 ☑ Natural 5 ☐ Pending	28a. Deta of Inju (Month, Da	y Year) 28b	Tima of Injury		. Inju Wo			28d. Describe t	now injury	y occurred			
Division	Attending ir death. ector: Atta by the fune	ficat	2 Accident invastigatio 3 Suicide 8 Could not b		line At home	torm etro	M lacton o		Yes 2□1		28f. Location (5	Street and	1 Number	or Pitral	Poute Mun	har
5	after Dire	Certification:	4 ☐ Homicide data mined	building, at	c. (Specify)	tarri, stra	iat, taolory, c	JIIIOO			City or Tow	vn, State))	J1 110/41	710010 14011	501,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Cartifiar (Check only one)	ysician: To the best ninar: On the basis of and mannar st	f axamination a	ge, death and/or inv	occurred at a stigation, in	tha ti	me, date and opinion, daat	d place, th occurr	and dua to tha dred at tha tima,	causa(s) date and	and manni piaca, and	ar as sta I dua to	ated. tha causa(s	;)
	To the within 2 To the comple	Me	29b. Signatura and titla of certifiar		A.		29c. L	icens	sa number			29d. Data	a signed (A	Aonth, E	Day, Year)	
	12		Comul 6	, Olam	L		1	>	349	5-1		1	-20	1-9	X	
	00		30. Nama and addrass of person who	completed cause of d	leath (Itam 23a	(Type, E	Print)	ch	El.	hno	£ 100	Col	nml	le)	D 2	1558
	Sta		31. Data filed (Month, Day Year)	402 Reduce												
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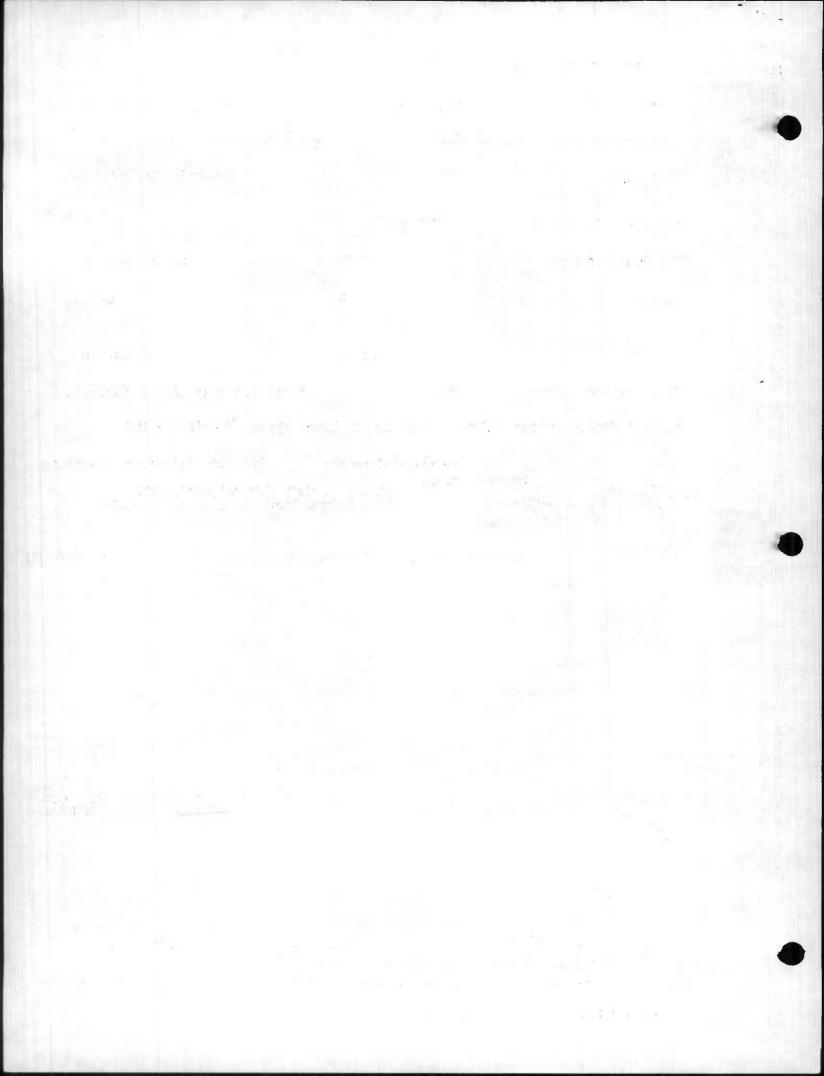
State of Maryland / Department of Health and Mental Hygiene-Items: 4ab.26 Per Phy Film G-755 1-30-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Daath 3. Tima of Death Month
JANUARY 10 836am **Physician** MARIE CHASON /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City Fown, on bocation of Death 4c. County of Death Examiner BALTIMORE HOPKINS HOSPITAZ BALTIMORE JOHNS 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Deys Hours 1 M 2 X F Yrs Director September 9,1913 Maryland 213-46-4739 the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, in a Modical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Maryland Parkville 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? Funeral 3007 DuBois Avenue 21234 United States filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 [X] No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 Realtor Real Estate Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) . Pages 1 end 2 should be fill ment of Health end Mental Hant: If Item 27 is marked oth jury or other traumatic even Be Harry Wilber Dove Wilhelmina Rosa Louisa Kohlheim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Coda) 6009 Church Lane Hydes, Maryland 21082 Date 20c. Location - City of Date 2 Mr. Earl Ronald Chason / Son Baltimore, 20c. Location - City or Town, State 1 X Burial 2 □ Cramation 3 □ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 1/14/98 | Baltimore, Maryland 21. Signature of Funeral Service Licensee / Timothy S. Harman 22. Nama and Addrass of Facility Leonard J. Ruck Funeral Home, Inc. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failufe. List only one cause on each line. Approximate intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final AMYUTROPHIC LATGRAL SCLEROSIS 11 months diseasa or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificete be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medicai Due to (or as a consequence of): nse P.O. Part It. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part it. 23b. Did tobecco usa contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown ate has been signed pege 2 should be de Records, þ 24b. Ware autopsy findings available prior to Be Completed 24a. Was an autopsy performad? completion of cause of death? 1 Yes 2 No certificate Division of Vital or Attending Physician: 25. Was case refarred to medical 26. Place of Daath (Check only one) SON & DAUGHTER-in-LAW'S examinar Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Thesidence 6XXXOthar (Specify) RESIDENCE 1 Yes 2 No Certification: To this 28a. Date of injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation efter death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) in by 4 Homicide 24 hours Hospital 1 Cortifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier Medical (Check only one) within 2 To the ţ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 1/10/98 D42763 30. Nama and addrass of person who complated causa of death (item 23a) (Type, Print) ANDREA CORSE MO MEYER 5-119 600 N. WOLFEST. BACTIMORE, MD 21287

State Registrar

31. Date filed (Month, Day, Year) 3 0 1998

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth Month LEE CHANDLER IMMY 20:05 PM 1998 JANUARY 26 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Union Memorial Hospital Baltimore N/A 8. Date of Birth (Month, Day, Yea DEC 24,] If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) Months Deys 1⊠M 2□F Hours Yrs. 216-48-1130 51 1946 Georgia Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4109 Roland Avenue 21211 USA 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: 3 ☐ Widowed 4 1 Divorced 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Bartender Restaurant 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Walter Lee Chandler Mae Ernestine Lindsay 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Brian Lee Chandler/Son 8063 Roslyn Ave. Rosedale, MD 21237 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremation 3 ☐ Remove from State Metro Crematory, Inc. 01/28/98 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Se 22. Name end Address of Facility Cremation Society of MD, Inc. A. Gregorchik Edward 299 Frederick Rd. Baltimore, MD 21228 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in deeth) · METASTATIC BILE DUIT ADENOCARCINOMA 6 Months Due to (or es e consequence of): Due to (or es e consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? 1 Ves 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

physician and the buriel-transit

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After

To the Hospital or Attending Pi within 24 hours efter death. To the Funeral Director: After the completely filled in by the funera

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Completed

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Certification:

Medical

certificete be exec Box 68760.

Division of Vital Records, P.O.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examiner must be nigitized at

permit. Peges 1 and 2 should be filed within 72 hours efter death a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23s eny Injury or other traumetic avanta.

Baltimore, Maryland 21215-0020

with the Marylend

Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet inlitieted events resulting in deeth) Lest Physician/Medical

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case referred to medical examiner? 1 Yes 2 No

26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA

27. Menner of Deeth 1 Naturei 2 Accident 3 ☐ Suicide

4 Homicide

28e. Dete of Injury (Month, Dey Year) 5 Pending investigation 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Hospitel:

28b. Time of 28c. Injury et Work? 1 Yes 2 No 28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only 15 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.
2 Medicel Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner stated.

29c. License number

29b. Signature and title of certifier,

AT2438946-M8 JANUARY 26 1998

29d. Date signed (Month, Day, Year)

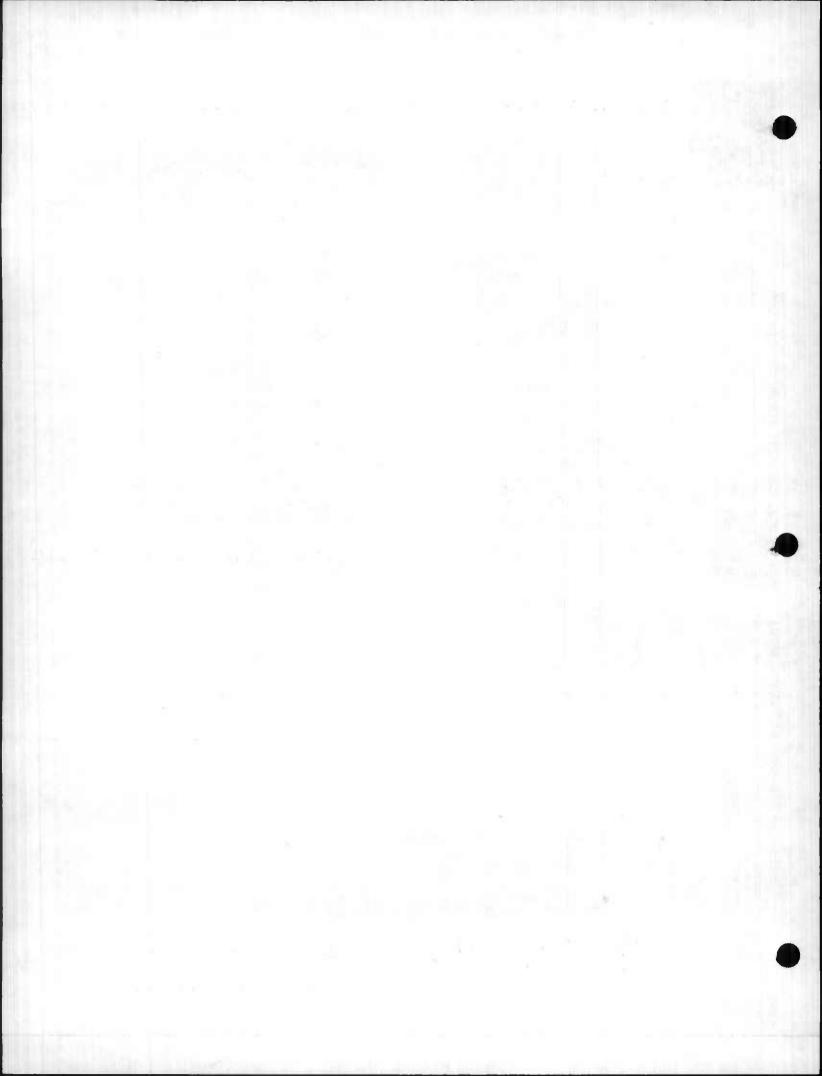
30. Name and eddress of parson who completed ceuse of death (Item 23e) (Type, Print) EY M. D 201

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DERON 0

E. UNIVERSITY PARK WAY, UMH 32. Regist/ar's Signature who Davidson

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Deeth Month :41 PM CULLY CHUSTOPHER 27 JAN 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, giva straet and number) 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) Months Days Hours 10 M 2 □ F Yrs. 43 111 44 3786 March 21,1954 New York Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Maryland Anne Arundel Crofton 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 1721 Denton Court 21114 United States 14. Race - Amaricen Indien, Black, Whita, atc. 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 11. Marital Status 1 ☐ Yes XXXIVo If Yas, Giva Yaar or Datas: 1 Navar Married 2 Marriad 1 Yas 2 No Spacify: 3 Widowad 4 Divorced White 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada com mpleted) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Director Plant Operations Holy Cross Hospital 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) John Cully Mary McLoughlin 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 1721 Denton Court Crofton Maryland 21114 Rebecca S. Cully Wife 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition XX Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Fair View Cemetery Jan. 31, 1998 Middletown N.J. 21. Signatura of Funaral Sarvice Licens 22. Nama and Addrass of Facility Robert E. Evans Funeral Home, Inc. nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, hy one cause on each line. Approximata intarval Batwaan Onsat and Daath Entar tha disaasa, of , or haart failura. List Immediata Ceusa (Finel diseesa or condition rasulting in daath) BILKERAL 51465 Sequantially list conditions, if eny, leading to immedieta causa. Entar UndarlyIng Causa (Disaasa or Injury Dua to (or as a consequence of): that initiated events rasulting in death) Last Due to (or es e consequance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying couse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings eveilable prior to 24a. Was an autopsy completion of causa of daath? 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was cesa rafarrad to medical axaminar? 26. Placa of Daath (Chack only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Inpatiant 2 ER/Outpatient 3 DOA

28d. Dascribe how injury occurred

mones Ceny Dr. Rockylle, sho

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29d. Data signad (Month, Day, Year)

Examiner physician end s the buriel-transit be executed Box 68760 98 951 for Division of Vital Records, P.O. deteched the signed by t d be detect peen hes director, funeral

Physician

/Medical

Examiner

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Funeral

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Item 27 is marked other than "natural", or items 23s or 25s-f show other traumatic event, the Medical Examinar must be notified at

12 should be filed within 72 hours effection and Mental Hygiene. Is marked other than "natural", or its

permit. Pages 1 end 2 st Depertment of Heelth end Important: if Item 27 Ia m any Injury or other traun pncs.

Physician /Medical

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Examiner Physician/Medical þ Completed Be 2 Certification:

24 hours e pletely Within 2 To the

After

s efter death.

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30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print) 31. Date filad (Month, Day, Yaar)
JAN 30 1998 Registrar

27. Mannar of Death

1 Natural

2 Accident

3 Suicida

29a. Cartifiar

Medical

4 Homicida

(Check only one)

29b. Signature at

5 Panding

title of certifier

invastigation

6 Could not be datamined

9707 32. Hogistrar's Signatura

28a. Data of Injury (Month, Day Year)

28b. Tima of

28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

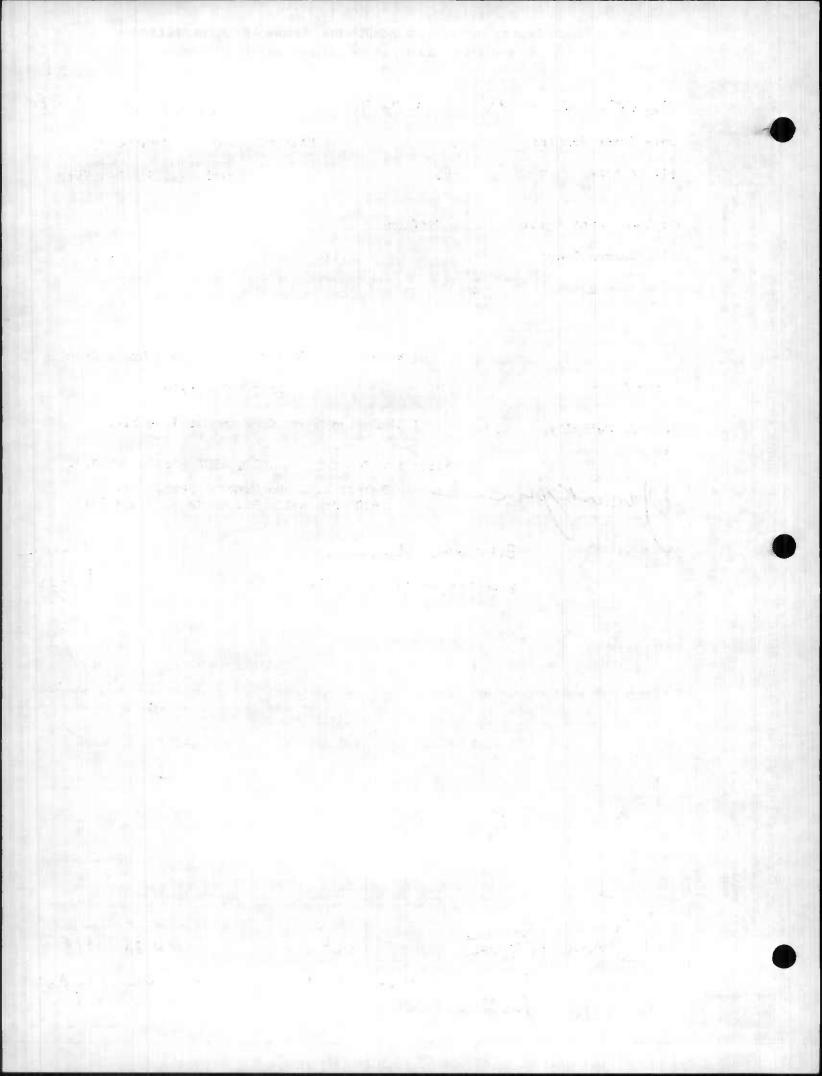
28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yas 2 ☐ No



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month January 1998 5:40 A. M. 20 Harry Cox 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore City Ravenwood Nursing Center If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Months Deys Yrs VA 76 April 27, 1921 224-28-4305 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Baltimore City N/A 10e. Street end Number 10f Zin Code 10g. Citizen of Whet Country? 21224 3412 E. Baltimore St. U.S.A. 12. Wes Decedent Ever in U,S.
Armed Forces?
1. Yes 2 No
If Yes, Give
Year or Dates: WW II 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Never Married 2 ■ Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Paper Shipping Specialist 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Alice Crabtree Charles Cox 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3412 E. Baltimore St. Baltimore, MD 21224 Carnett Green/Sister 20b. Plece of Disposition (Neme of cemetery, cremetory or other placa) 20e. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removal from State 1/23/1998 4 ☐ Donetion 5 ☐ Other (Specify) Gardens of Faith Cemetery Baltimore Chty., MD 21. Signeture of Funerel Service Licens 22. Name end Address of Fecility Moran-Ashton-Dabrowski Funeral Home, Inc. 3000 E. Baltimore St. Baltimore, MD 21224 23e. Pert1. Enter the disease, or complications that caused in the late. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Cause (Final disease or condition resulting in death) ears Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequença of) Due to (or es a consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 3 Probably 4 Unknown 1 Yes 2 No Zure 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Was en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

Physician /Medical Examiner

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Division of Vital Records, P.O. Box 68760, Hoppital or Attending Physician: The law requires that the death cartificate be expensed and the standing physician Physician Physician Standing physician Physicia

Physician

/Medical

Examiner

Director

Funeral

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Completed

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MD

Funeral

Director

Item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at

permit. Pagas 1 and 2 should be filed within 72 hours aftar in Department of Haalth and Mantai Hygiana. Important: if Itam 27 is marked other than "natural", or itea any injury or other traumatic event, the Medical Examinations.

3altimore, Maryland 21215-0020

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signed by

Examiner ettanding physician and for usa as tha bunal-transit Physician/Medical þ Completed Be 10 Certification:

26. Plece of Deeth (Check only one)

Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. injury et Work? 1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Certifying Phyelcien: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature end title of cartifier

5 Pending

Investigation 6 Could not be determined

29c. License number

29d. Date signed (Month, Dey, Year)

Hmatyn H. Hacem

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print),

Hospital:

Dolthin street NAREM 501

31. Date filed (Month, Day, Year) State JAN 3 0 1998 Registrar

1 ☐ Yes 2 No

27. Manner of Deeth

1 Neturel

2 Accident

3 Suicide

29a. Certifier

edical

4 Homicide

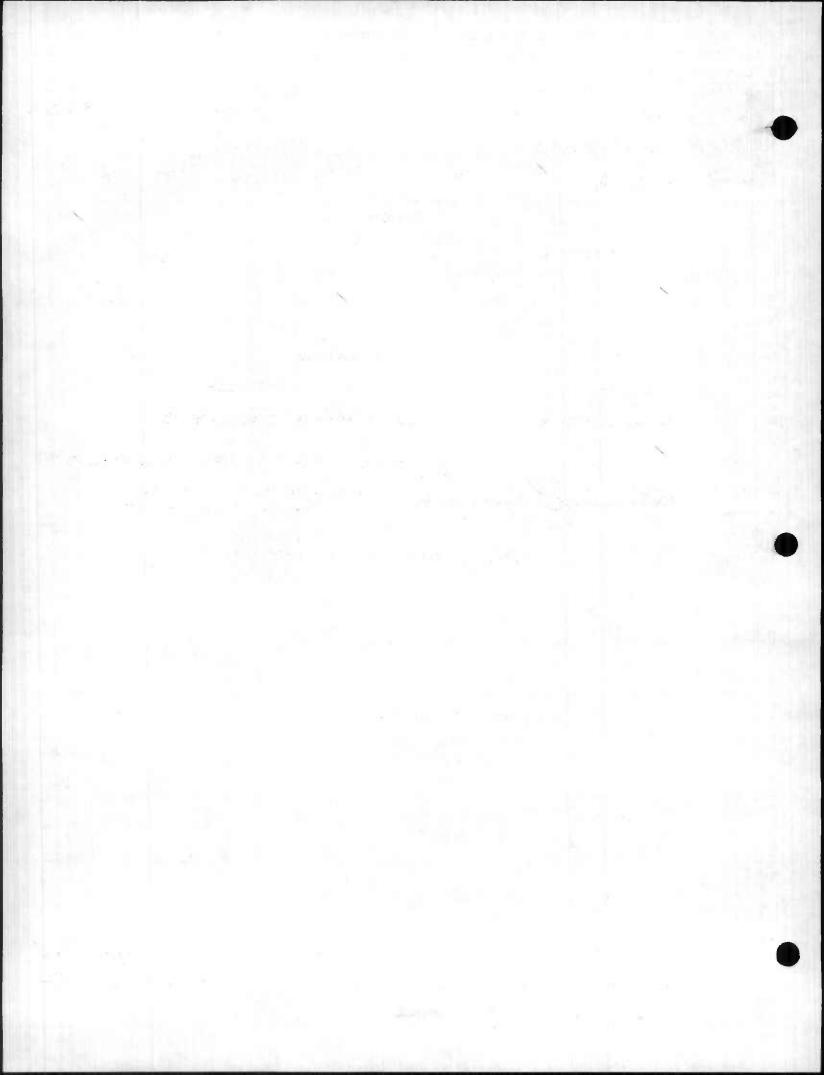
(Check only one)

32. Registrer's Signature

1 Inpatient 2 ER/Outpetient 3 DOA

DHMH 16 Rev 6/95

To the Y



98-0355-510_R. Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. COTTON State of Maryland / Department of Health and Mental Hygiene 2393 Certificate of Death Items:23a part I,II,27,28a-f per MEO G-756 2/25/98 dh 2. Date of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Lest) **Physician** JANUARY 23, 1998 08:30 AM THEORDORE /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner UNIVERSITY HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Pay Year) 1/23/1941 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** 1X M 2□ F Months Days Hours 57 Yrs. ALABAMA 421-52-3516 Director Usual Residence of Decedent tha Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or items 23s or 28s-f sho traumstic event, the Medical Examinar must be notified at 1 Yes 2 □ No MARYLAND Directo BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 441 EAST 28th STRRET Pages 1 and 2 should be filed within 72 hours after death nant of Health and Mantal Hygiens.

Int: If leave 72 is marked other than "naturat", or items 23 inty or other traumatic event, the Medical Examination man Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Saltimore, Maryland 21215-0020 Specify: AFRO. AMERICAN þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) KENNYCOTT- UTILITY MAN KENNYCOTT CO. 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 441 EAST 28th STREET, BALTIMORE, MARYLAND 21218 EMMA COTTON WIFE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. DRUID RIDGE CEMETERY 1/30/98 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee ESTEP BROTHERS FUNERAL HOME, P.A. LLDYD M. ESTER 1300 EUTAW PLACE, BALTIMORE, MARYLAND n1. _nl) the disease, or complications that caused the shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate Intervel Between Onset and Death ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE COMPLICATED BY CARDIAC Physician Immediate Cause (Final disease or condition resulting in deeth) ARRHYTHMIA DURING ANESTHESIA FOR REVISION OF LEFT LEG AMPUTATION /Medical Examiner Due to (or as a consequence of): Examiner certificata be axecuted physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 88 usa ò 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. P.O. signed by 1 Yes 2 No 3 Probably 4 thknown DIABETES MELLITUS (MEDICAL HISTORY) of Vital Records, þ 24b. Were eutopsy findings eveilable prior to 24a. Was an autopsy Completed completion of cause of death? page 2 s 1 Yes 2 No 1 Pes 2 No 25. Was cese referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 XYes 2 No funarai 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) Certification: A Attending vision 5 Pending Investigation 1 Naturel 1 Yes 2 No Accident 1/23/98 7:30 ARRHYTHMIA DURING ANESTHESIA 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) University Hospital, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homlcide pital of To hospita1 Baltimore, Maryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end menner as steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one)

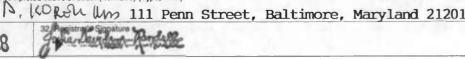
State Registrar

MARYAMOR 31. Dete filed (Month, Day, Year) 3 0 1998

well

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

29b. Signature and title of certifier



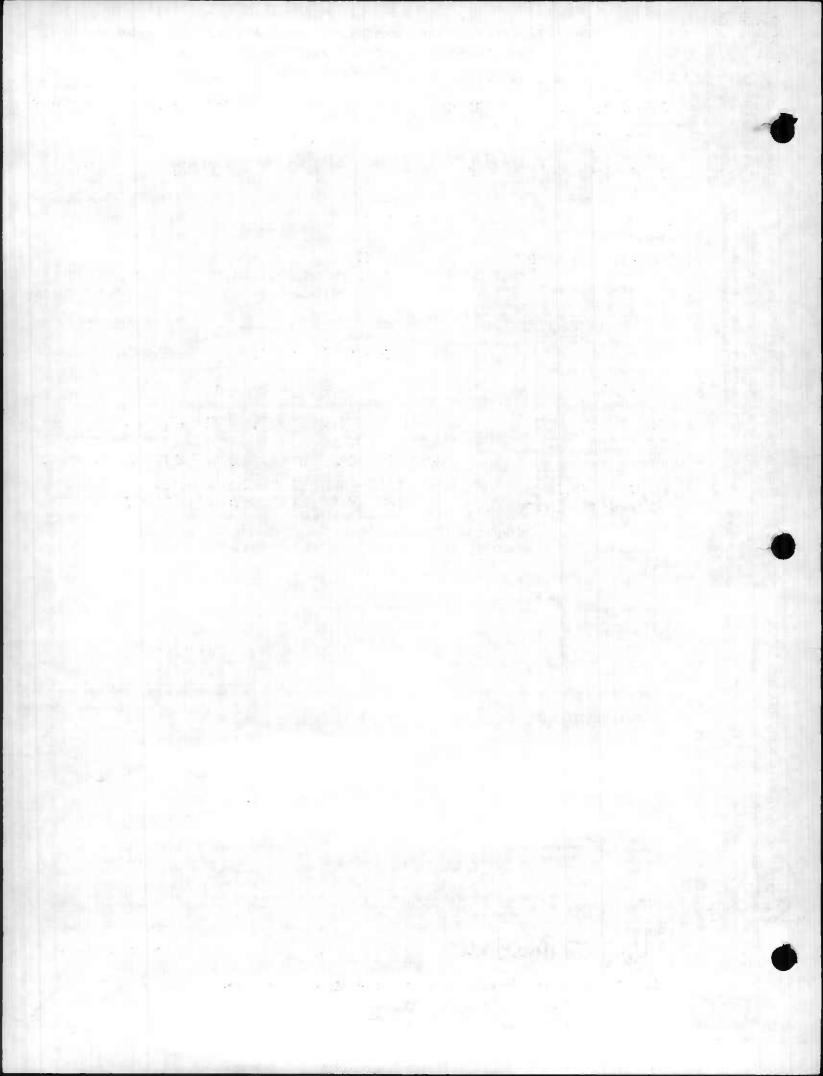
29c. License number

OCME

29d. Date signed (Month, Dev. Year)

JANUARY 24, 1998

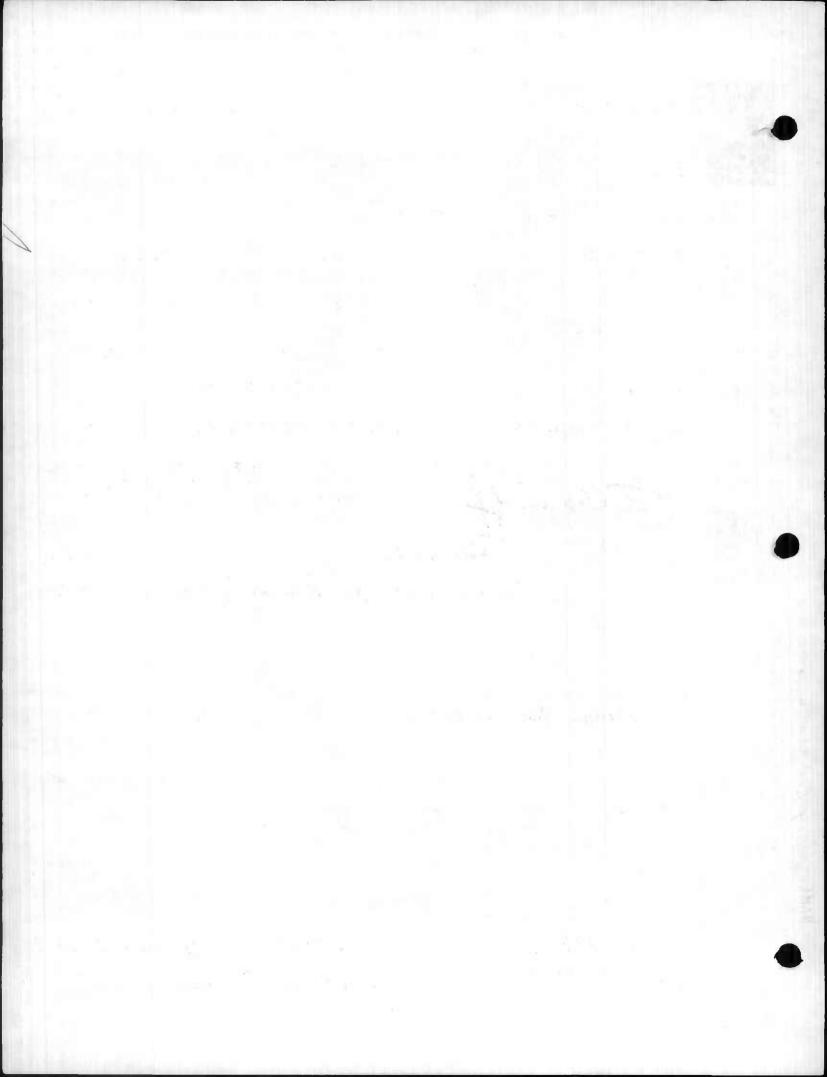
within To the



State of Maryland / Department of Health and Mental Hygiene

Physicia		1. Decedent's Name (First, Middle, L	ast)			tificate		2. Date of D			3. Time of Death
/Medic		MARY LOU CADIGAN						JANUAR	Y 28, 19	Year 98 1	:20 PM
Examin		4e. Fecility Neme (If not institution, gr	ve street end numb	ber)			4b. City, Town, o				
		SAINT AGNES HOSP	ITAL				BALTIMOR		N/A		
Funeral Director		212-26-1162	Sex 7. 1□ M ÆÆF	. Age (In yrs.	lest birthday) Yrs.	If Under 1 Y Months D	ear If Under 24 Hr ays Hours Mir	. (Month, D	irth ey, Year) 5, 1930		e (State or Fore
*		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Loc	cation					tnside City Ltm
28a-f show	ctor		PIMORE		CATONSV						1 □ Yes 2X
23a or 2	Funerai Director	705 CROSBY ROAD				10f. Zip Co	^{de} 1228		10g. Citizen of V.S.		7
netural, or items 23s or 28s-f show digal Examiner must be nutilised at	by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deced Armed Forc 1 Yes 2 If Yes, Give Year or Date	. No			of Hispanlc Origin? (Cuban, Mexican, Pue No Specify:	Specify Yes or N rto Rican, etc.)	o- 14. Rac Bta Specif	ce - American ck, Whita, etc.	
ene. than "natura he Medical E	Completed	15. Decedent's E (Specify only highest gr	iducation ade completed) Collaga (1-4	(or 54)	16a. Deced (Give I	ent's Usuat O kind of work d OO NOT usa re	ccupation ona during most of w etired)	orking	16b. Ktnd of B		
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al Hygi	Be	17. Fether's Neme (First, Middle, Las	t)				18. Mother's Ne	ame (First, Middle	e, Maiden Sumen	ne)	
marked	2	JOHN H. REAVIS					RUTH L	NEBERRY			
th end 7 Is m traum		19a. Informant's Name/Ralationship	(Type, Print)		19b. Maitin	g Address (Si	reet end Number or F	Rurel Route Numi	ber, City or Town,	Stete, Zip Co	de)
item 2		BRIAN J. CADIGAN 20a. Method of Disposition 1X Burial 2 Cremation 3		20b. F	P.O. Place of Dispos cematary, crem	BOX 24 sition (Neme of latory or other	08, ELLICO	Date Date	MARYLA 20c. Location		
		4 ☐ Donetion 5 ☐ Other (Speci			DDLAWN	CEMETE	RY	1/31/98	WOODLAW	N. MAR	YLAND
Depertmen Important any Injury once.		21. Signature of Funeret Service Lice		2	22	Name and A	ddress of Fecility WI	TZKE FU	NERAL HO	MES, I	NC.
hysician		23e. Part1. Enter the disease, or col shock, or heart failure. List only	nplications the cause on the	sed the deat						Ar	proximate erval Between iset end Death
/Medical xaminer		Immediate Cause (Finel disease or condition resulting In death)	a/	~	nonia					- 2	2 day
physician end the bunel-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Chr	mic	or as a consequence of the conse	ufue	Pulmer	7 Mise	ise	4	lyew
. 0.0	900	rasulting in death) Last	d	Due to (o	r es e consequ	ence of):					
d for use	Icia	Part II. Other significant conditions	contributing to deat	th but not ree	ulting In the un	deriving cause	a given in Dert t	22h D#	I tobacco une co	intribute to th	a course of don
neen signed by the ettendin	y Physician/	Wrinay	1 1	njec	1 -	denying caus	a given in Pert i.	1/4	Yes 2 No	3 Probab	
houl	Completed by	/	•	/				24a. Wa	s an autopsy formed?	avalla	autopsy finding ble prior to etion of cause th?
certificate has birector, page 2 s	mo:							1 🗆	Yes 2DNo	1 🗆 Y	es 21 No
ctor, I	Be	25. Was cese referred to medicel examiner?					26. Placa of Da	ath (Check only	ona)		
this certific ral director,	2	1 Yes 2 No	Hospital: 1 Inp	patient 2 3	ER/Outpatient			Home 5□Res	idence 6 □Oth	ner (Specify)	
r death. sctor: After the by the funera		27. Menner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury Day Year)	28b. Time of tnjury	28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occur	red	
within 24 hours effer death. To the Funeral Diractor: After completely filled in by the funeral compl	Medical Certification:	3 ☐ Suicide 6 ☐ Could not to detarmined	286. Place of	f Injury - At h	ome, farm, stre	et, factory, of	fice		(Street end Numl own, Stete)	ber or Rurel R	oute Number,
• Funeral	dical	29a. Cartifiar 1 Certifying Pl (Check only one) 2 Medical Exa	nysfctan: To the ba mfner: On the basi and manne	Is of examina	wladga, daath tion and/or Inv	occurred at the estigation, in	na time, date and place my opinion, death occ	e, and due to the curred at tha time	cause(s) and mand and place,	anner as state and dua to the	d. a cause(s)
To the comple	Me	29b. Signature and title of certified				29c. Li	cense number		29d. Date signe	d (Month, De)	, Year)
0		> Bunk yes	(2m)			7	38543 Avenue		Janua	cry 28	,1998
14	1	30. Name and address at	completed ceuse	md at a - 10. 444	0001 00 11 5)_i=4\					

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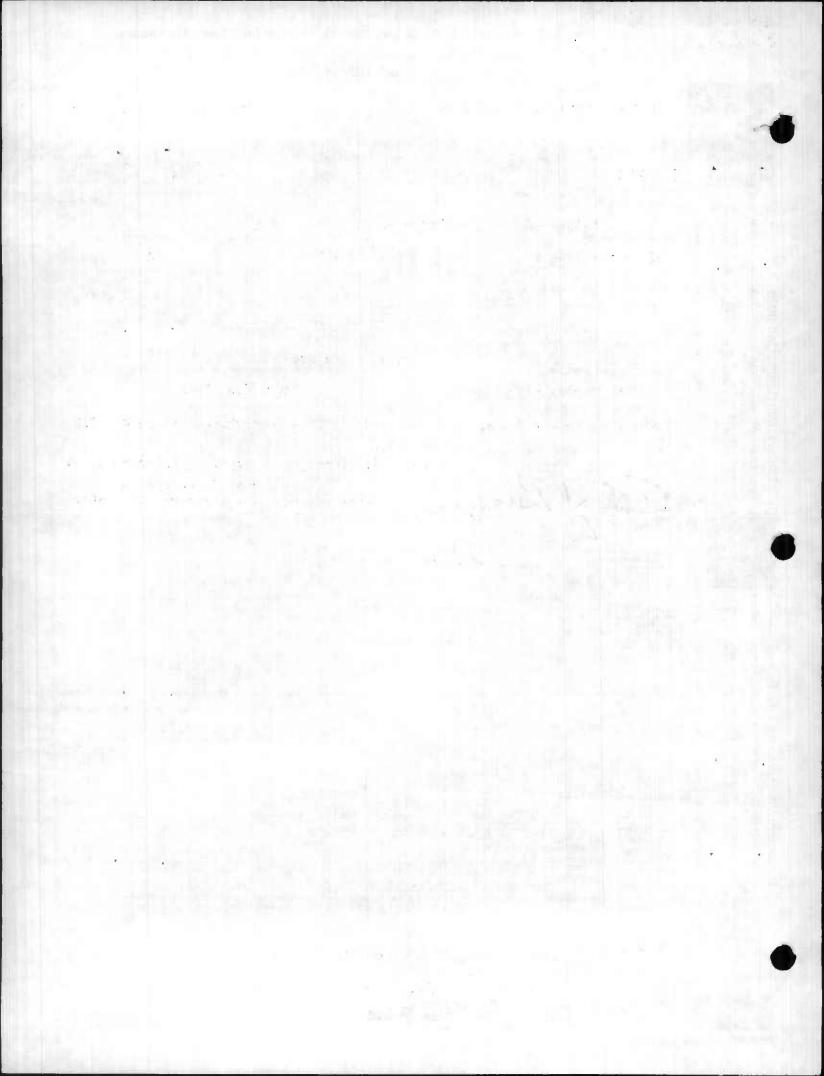


III Penn Street, Baltimore, Maryland 2/201

State Registrar Stephen S.

Radentz

32. Registra 's Stgnatur



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Item: 10f per Informant State of Manyland Department of Health and Mental Hygiene Certificate of Death Items: 24a, 25, 26, 27 per MD G-755 1/30/98 dh Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Dev **Physician** Virginia Grace Durish 5, 1998 09:20PM JANUARY /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Min 1□ M 21 F 252-03-6705 86 Yrs. Sept. 7, 1911 South Carolina Director Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Randallstown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23e or traumatic event, the Medical Examiner must be 2815 Paper Mill Road 21133 21131 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, 2 No If Yes, Give Yeer or Detes: 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merrled altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Police Receptionist 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pagas 1 and 2 should be file.
Department of Haalth and Mental Hy
Important: If Itam 27 is marked oth-17. Fether's Neme (First, Middle, Last) Joseph Thomas Martin Lizzie Lee Willis 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Nancy Sutton/daughter 4305 Sweet Air Road, Baldwin, Maryland 21013 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 5 Other (Specify) 4 Donation 21. Signature of Juneau Service Vocase Wate, Director 22. Name end Address of Fecility State Anatomy Board, 655 W. Baltimore Street werdell. Baltimore, Maryland 21201 23a Flatt. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, lock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Cardo pulnernaly failur
Due to (or es e consequenca ot): Examiner Examiner physician and tha buriel-transit cartificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequença of): onen Physician/Medical that initiated events resulting in deeth) Lest Due to (or es e consequence of): 80 usa 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, P. þ 50 24b. Were eutopsy findings aveilable prior to completion of ceuse of death? Completed 24a. Was en eutopsy cartificata has b 1 ☐ Yes 2XXNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2/17 No Malinpatient 2 □ ER/Outpatient 3 □ DOA funaral 28b. Time of 28d. Describe how Injury occurred 27. Menner of Deeth 28c. Injury et Work? Certification: After 5 Pending investigation 1 X Netural 1 ☐ Yes 2 ☐ No deeth. 2 Accident efter deet Director: 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours efter Funeral Dire

Registrar

Medicai

31. Date filed (Month, Dey, Year)

29b. Signeture end title of cartifier

29a. Certifier

(Check only one)

E.A. RAZZAR

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

32. Registrer's Signeture Chia Savidson-Randall

12 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menner stated.

29c. License number

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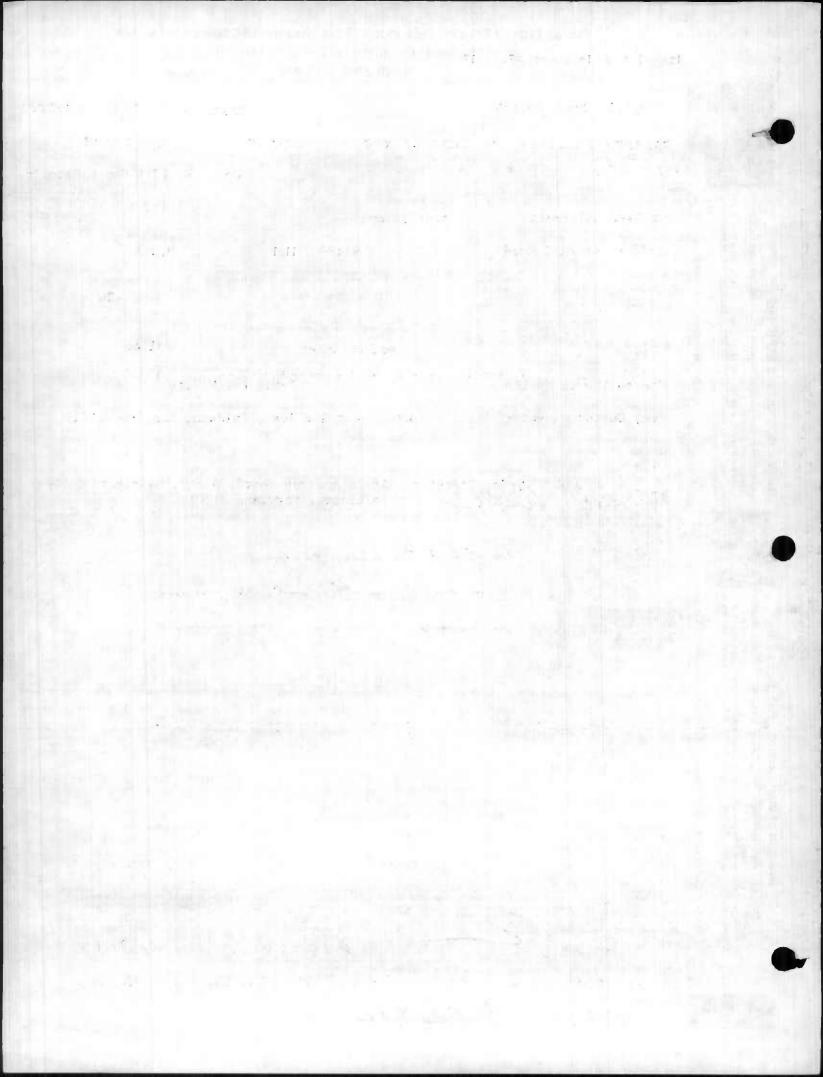
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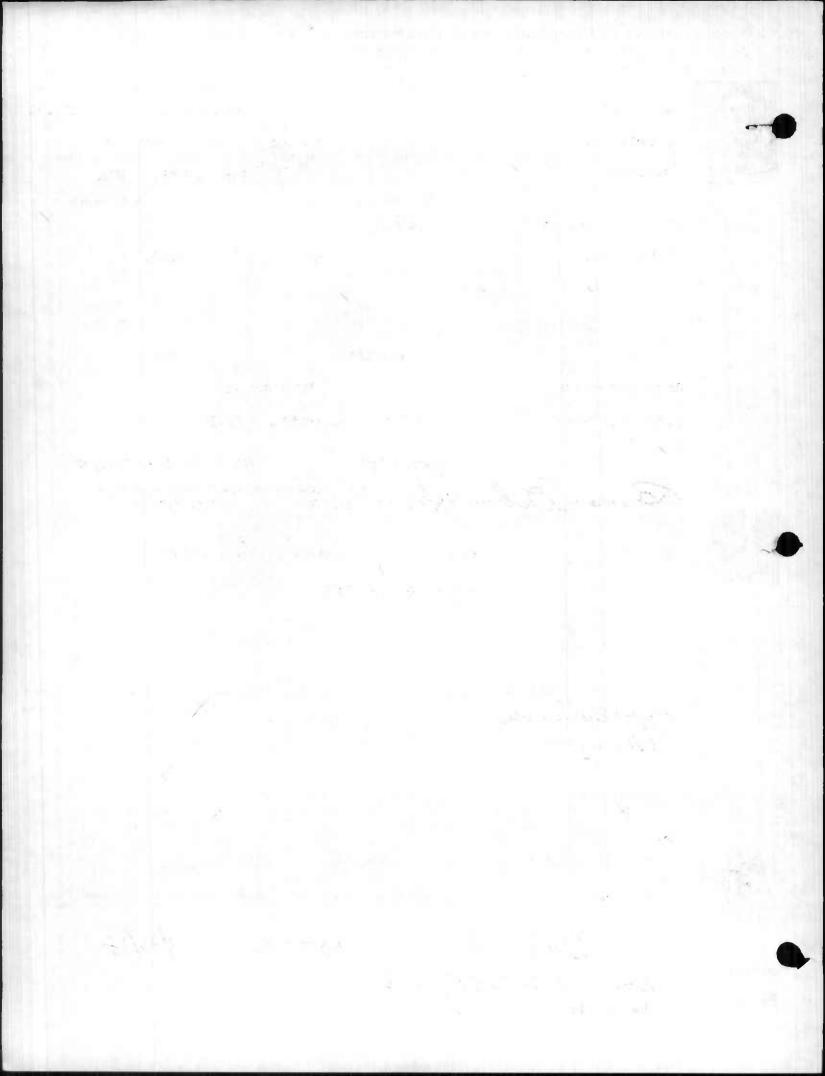
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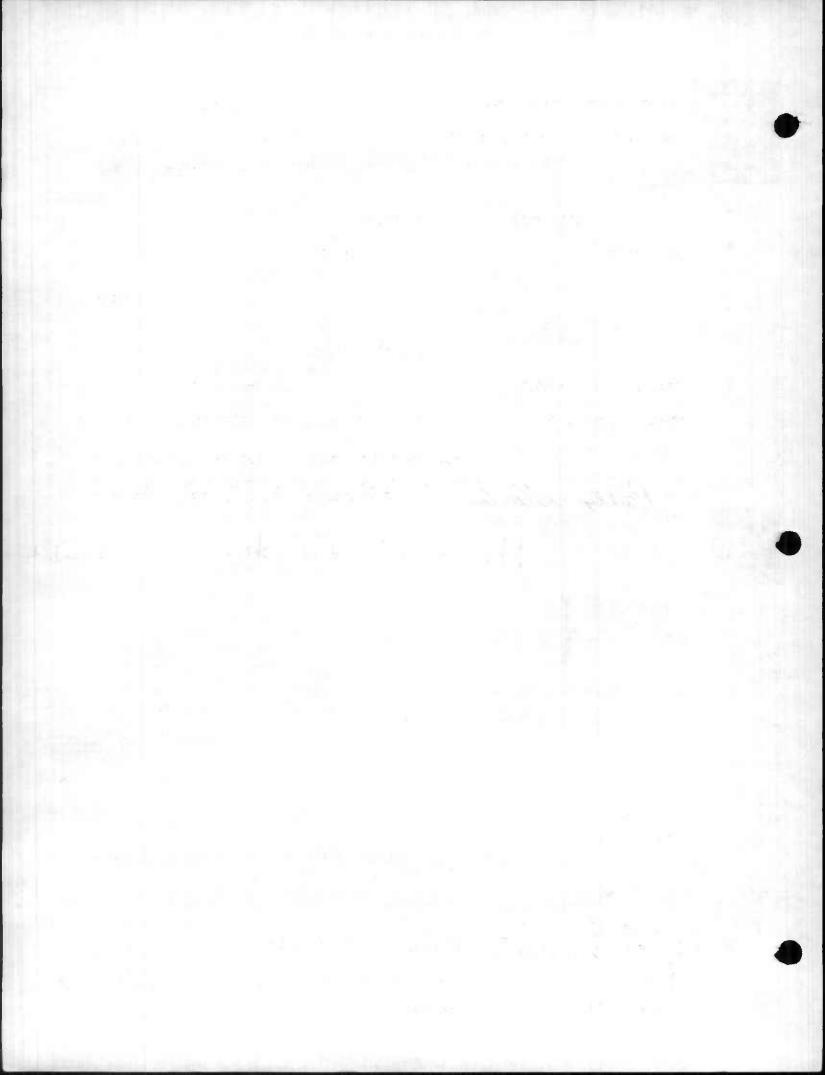
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important: if item 27 is merked other than "natural", or items 23a or 28e4 show any injury or other traumatic event, the Nedical Examiner must be notified at long any injury or other traumatic event, the Nedical Examiner must be notified at long and long	MD 10e. Street end Number 821 Loalan 11. Marital Status 1 Never Marrier 3 Widowed 4 (Specification of Proceedings of Procedures of Proceedings of Proceedings of Proceedings of Proceedings of Procedures of Procedures of Procedures of Procedures of Procedures of Procedures of Procedures of Proceedings of Procedures o	Ave. Paltimober Ave. Ave. Decedent 10b. County Paltimober Ave. d 22 Married Divorced 15. Decedent's Edy only highest gradary (0-12) First, Middle, Last) Ferrell me/Reletionship (1-11)	e street end num ex M 2 F 12. Was Dece Armed For 1 Yes, Givy Yeer or Da lucation de completed) College (1-	7. Age (In yrs. 53 10c. Ci dent Ever in toes? 22 No	16a. Deced	If Under 1 Year Months Days cation IK 10f. Zip Code 21 Ves Decedent of In Yes, specify Cub Yes, Specify Cub Yes 22 No ent's Usual Occup kind of work done	pation	8. Date of Bit (Month, De June 22)	Day 23, 199 h 4c. Cou Bai th yy, Yeer) , 1944 10g. Citizen o U-S-A	Yeer 8 Inty of Death Itimore 9. Birthplace Country) W VA 10d. of Whet Country's Race - American is Bleck, White, etc.	Indien,
tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at the To Be Completed by Funeral Director	5. Sociel Security Nu 218-44-244F Usuel Residence of I 10e. State MD 10e. Street end Numl 821 Loalan 11. Marital Status 1 Never Marries 3 Widowed 4 (Specific Elementary/Second 12 17. Fether's Neme (F Joseph Ross 19e. Informant's Nan James Donat 20a. Method of Dispo	Ave. mber 6. S Decedent 10b. County Baltim ber Ave. d 22 Married Divorced 5. Decedent's Ed y only highest gradary (0-12) Ferrell me/Reletionship (1-11) in/Reletionship (1-11)	12. Was Dece Amed For 1 _ Yes If Yes, Give Yeer or Da lucation de completed)	7. Age (In yrs. 53 10c. Ci dent Ever in toes? 22 No	Yrs. Dunda Dunda J.S. 13. V If 1 16a. Deced (Give lifte. L)	If Under 1 Year Months Days cation IK 10f. Zip Code 21 Ves Decedent of In Yes, specify Cub Yes, Specify Cub Yes 22 No ent's Usual Occup kind of work done	Dundalk If Under 24 Hrs. Hours Min. Min. 2222 Alispenic Origin? (Stan, Mexicen, Puerto Specify:	8. Date of Bit (Month, De June 22)	Bainth Pay, Year) 10g. Citizen C U-S-A	9. Birthplace Country W VA 10d. of Whet Country and C	tnside City Limita 1 □ Yes 2 Ø No ? Indien,
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page 2 should t	Ober	ity							en eutopsy ormed?	eveilel	eutopsy findings ble prior to etion of cause th?
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inactor sinactor o Be	25. Was cese referre examiner?		Hospital:			Ott	26. Plece of Dee	12			
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oy the funer ffication:	2 Accident 3 Suicide	5 Pending investigation 6 Could not be determined	28e. Place	of Injury - At h	Injury ome, farm, stre		rk? Yes 2□No			mber or Rurel Ro	oute Number,
S P	4 ☐ Homlcide 29a. Certifier			g, etc. (Special		occurred at the tir	me, date end place,	City or To		menner ee state	4
B S	(Check only 2 one)	☐ Medical Exem	Iner: On the bas	sis of examina	ation and/or inv	estigation, in my o	pinion, death occur	red et the time,	date end pled	ce, end due to the	ceuse(s)
Me	29b. Signeture end tit	tle of certifier	,	1		29c. Licens				ned (Month, Dey	
1177	1	1. Cul	Yer r	ne)) à	77220)	1/2	4/26	
L	30. Name and eddres	ss of person who a	CUT A	of death (Iter	m 23e) (Type, F	Print) 1007	NORTH Poin	+ Blvd.	Baltimo	re, MD	21224



		1. Decedent's Neme (First	t, Middle, i	Last)				Death		2. Dete of De	Reg. No. 🔑 🕓	3	3. Time of Death
cian dical		HENRY ALBER	RT DE	BAUGH, S	SR.					Month 01/24	Dey /1998	Voor	2235
iner	4	4a. Facility Neme (If not in HOWARD COUNT							UMBIA	cation of Death	4c. County	y of Deeth	
		5. Social Security Number		. Sex		s. lest birthday)	If Under 1 Year					OWARD	e (State or Forei
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Dire		10e. Street and Number					10f. Zip Code				10g. Citizen of	,	?
679	0 .	145 LONGVIEV 11. Marital Status	V DRI		cedent Ever in	U.S. 13 V	Vas Decedent of		igin? (Spe	cify Ves or No		.S.A.	Indien
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peter	2	15. De	ecedent's	Education	1	16a. Deced	dent's Usuel Occu	petion	et of work in	20	16b. Kind of B	usiness/Indust	try
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P		WILLIAM EDGA								CKITTRI			
		19e. Informent's Neme/Re HENRY A. DEE					ng Address (Stree WESTCHES						
	-	20a. Method of Disposition		,	20b.	Place of Dispo				Date	20c. Location -		
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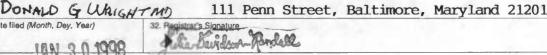


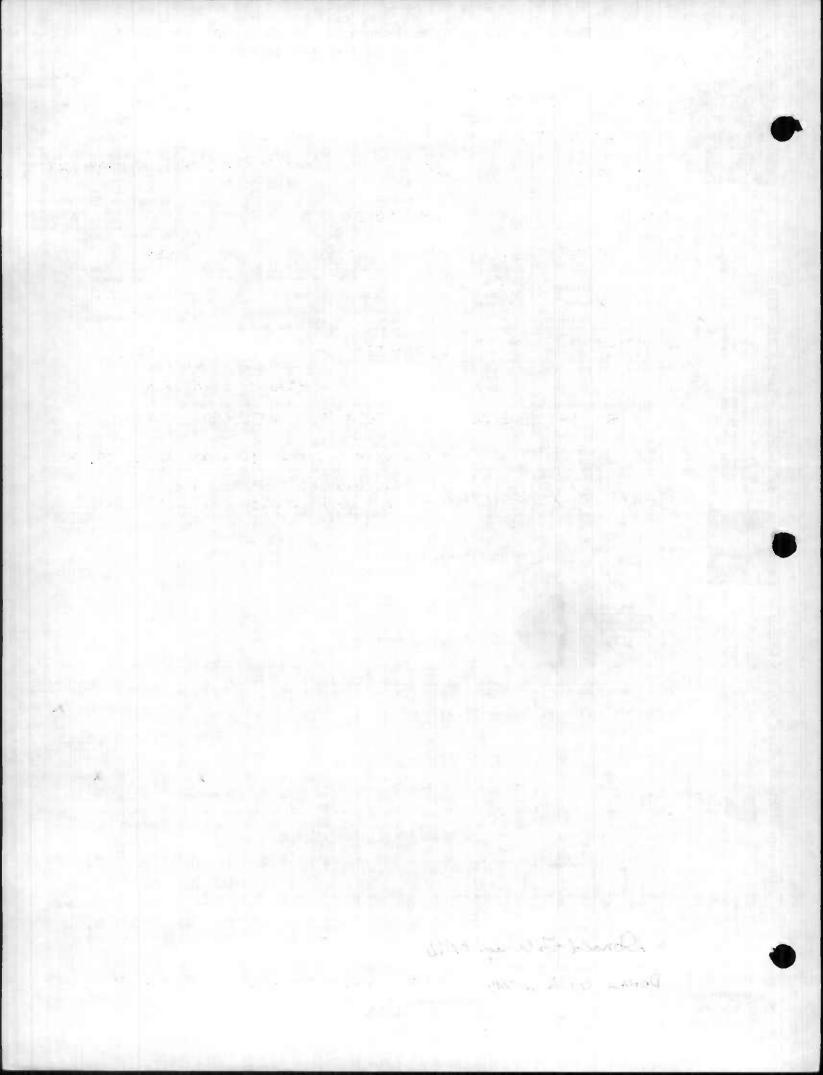
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene CAROLYN DEMBECK Certificate of Death Reg. No. Items: 23a part I, II, 27, 28a-f per MEO G-757 3/5/98 dh 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Month **Physician** CAROLYN DEMBECK 18, 1998 11:28 AM JAN. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner CHURCH HOME HOSPITAL I.C.U BALTIMORE 5 Social Security Number If Under 1 Year 8. Dete of Birth (Month Dey, Yeer) 9. Birthplece (State or Foreign MARTY) LAND 6 Sex 7. Age (In vrs. lest birthdev) **Funeral** 1 M 2 F Months Days Hours Min 56 Yrs. 217-38-9917 Director Usual Residence of Deceden with the Meryland 10a State 10b County 10c. City, Town or Location 10d. inside City Limits 7 is merked other than "natural", or items 23s or 28s-f show traumatic event, the Mexical Examiner must be notified at 1 TYes 2 □ No Director MARYLAND N/A BALTIMORE 10a. Street end Number 10f. Zip Code 10g. Citizen of What Country? 313 S. WOLFE STREET 21231 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Race - American Indian pemit. Pages 1 end 2 should be filed within 72 hours after d Department of Heelth and Mental Hygiena. Important: if Item 27 is marked other than "natural", or Nem any Injury or other traumatic event, the Medical Exempter Black, White, etc. 1 ☐ Never Merried 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: by 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collage (1-4or 5+) CASHIER SALES 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Maiden Sumeme) Be LEO PAULINE SWINKOWSKI 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 9224 TODD AVE. MR. & MRS. RAY DEMBECK MARYLAND 21052 Saltimore. 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriai 2 Cramation 3 Removal from State HOLY ROSARY CEMETERY 1-28-97 BALTO. CO. MD. 4 Donation 5 Othar (Specify) 22. Name and Address of Fecility
KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVE. BALTO. MD. 21222 ns that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, us on each lina. Approximete Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final THEOPHYLLINE INTOXICATION disease or condition resulting in daath) Examiner Due to (or as e consaquence of): Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es a consequence of) as usa for ed by tha e 23b. Did tobacco use contributs to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yas 2 No 3 Probably 4 Unknown SEVERE CORONARY ARTERY ATHEROSCLEROSIS, CHRONIC OBSTRUCTIVE Records, à 24b. Were eutopsy findings available prior to Completed 24a. Was en autopsy performad? peed PULMONARY DISEASE completion of ceuse of death? has 1 Yas 2 No certificate 1 Yas 2 □ No Division of Vital funaral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 XX Yes 2 No XXnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dev Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: 28b. Time of After 1 Naturel 5 Pending death. 1 Yes 2XXNo Hospital or Attendi
 24 hours after death.
 Funeral Director: A Investigation 2 Accident 1/17/98 unknown unknown 6 Could not be determined 3 Suicide 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 313 S. Wolfe St., filled in by 4 ☐ Homicide found at home Balto. City, Md. 29a. Cartifie 1 Cartifying Phyaician: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. completaly (Check only one) Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the F within 2 To the F 29b. Signatura and titla of certifier 29c. Licanse number 29d. Date signed (Month, Dey, Year) Donald Go Wright MD JAN. 19, 1998 O.C.M.E 30. Name and address of person who complated causa of daath (Itam 23a) (Type, Print)

State Registrar

1881 3 0 1998

31. Date filed (Month, Dey, Year)





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 23 part I, per Physician G-755 1/30/98 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth January 13 1998 PAMELA MARIE DACHILLE 4b. City, Town, or Location of Deeth 4c. County of Death

3. Time of Death

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

Physician

/Medical

4e Fecility Neme (If not institution, give street end number)

To the Hospital or Attend within 24 hours effer death To the Funeral Director: completely filled in by the

A	LAGITITIE	г	CARROLL	COUNTY	GENERA	AL HO	OSPITA	L			WESTM	INST	ER	C	ARR	OLL		
	Funeral Director		Social Security N	Vumber	6. Sex 1 ☐ M 23	7.		. last birthdey)	If Under Months			24 Hrs. Min.	8. Date of B (Month, D NOV • 2	irth ey, Year) 1,195	54	9. Birthp Coun MARYI	plece (State) LAND	ate or Foreign
	79	U	suel Residence o	of Decedent														
	4 show		De. Stete MD	10b. County CARR	OLL			Ity, Town or Lo								1		e City Limits Yes 211 No
	ter deeth with the Merylen terms 23s or 28s-1 show the must be notified at Tuneral Director		De. Street end Nu		D				10f. Zlp 21	Code 158						Whet Cour		
020	by F		Meritel Status Never Man Widowed		ied 1 If Y	s Decedened Force 1 Yes 2 es, Give ar or Dete	™ No		Was Deced	ify Cub	en, Mexican	gin? (Sp , Puerto	ecify Yes or N Rican, etc.)			ce - Americ ck, White, WH	etc.	n,
Ö	natural,			15. Deceden				16e. Dece	dent's Usue	Occup	petion			16b. Kir	nd of Bu	usiness/Inc	dustry	
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Baltin	permit. Pego Department: Important: If any Injury or phose.	2	1. Signeture of F			n	een	22	2. Name en	d Addr	ess of Fecilit	у (91 WILI WESTMIN	JIS STER	TREE, MI	ET 211	57	
	Physician /Medical Examiner Examiner Examiner	fr	3a. Pert1. Enter shock, or hear shock, or hear mmediate Ceuse isease or conditions soulting in deeth)	(Final			OCYTIC SI		ITIS	e of dyi	ing, such es	cerdiec	or respiretory	errest,		0	Onset	Imete Between end Deeth Week
68760,			equentially list co eny, leeding to in ause. Enter Und leuse (Diseese or leet initiated event ssulting in death)	r Injury	b			(or es e consec										
Вох 68	ording phuse es the	1	ssulfing in death)	Lasi	d													
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vision	r death. ector: After t by the funere ification:		2 Accident 3 Suicide	investiq 6 Could determ	not be	Plece of	f fnjury - At	home, ferm, st				140	28f. Location	(Street an	d Numi	ber or Run	e <i>i Route</i>	Number,

State Registrar

edical Certifica

4 Homicide

29b. Signature end title of certifier

A

29a. Certifier (Check only one)

Enrico

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

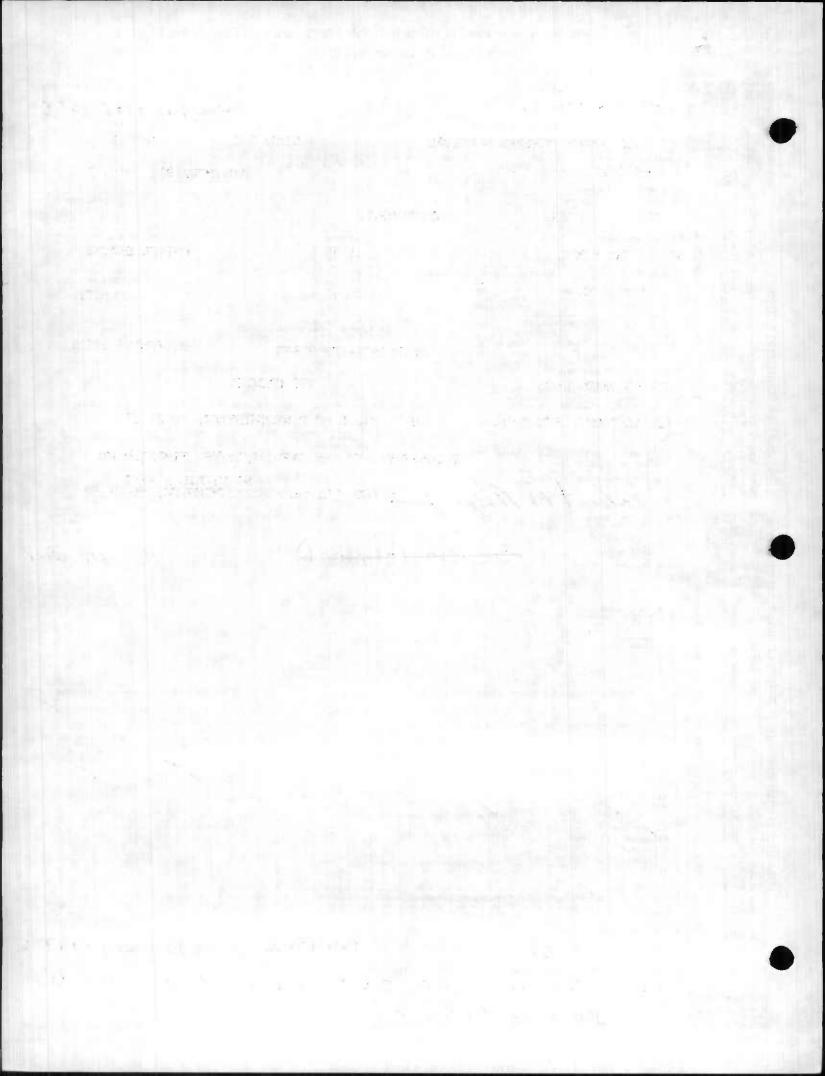
. Giangeruso, MD

28e. Plece of fnjury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Certifying Phyeicfan: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated.

29c. License number

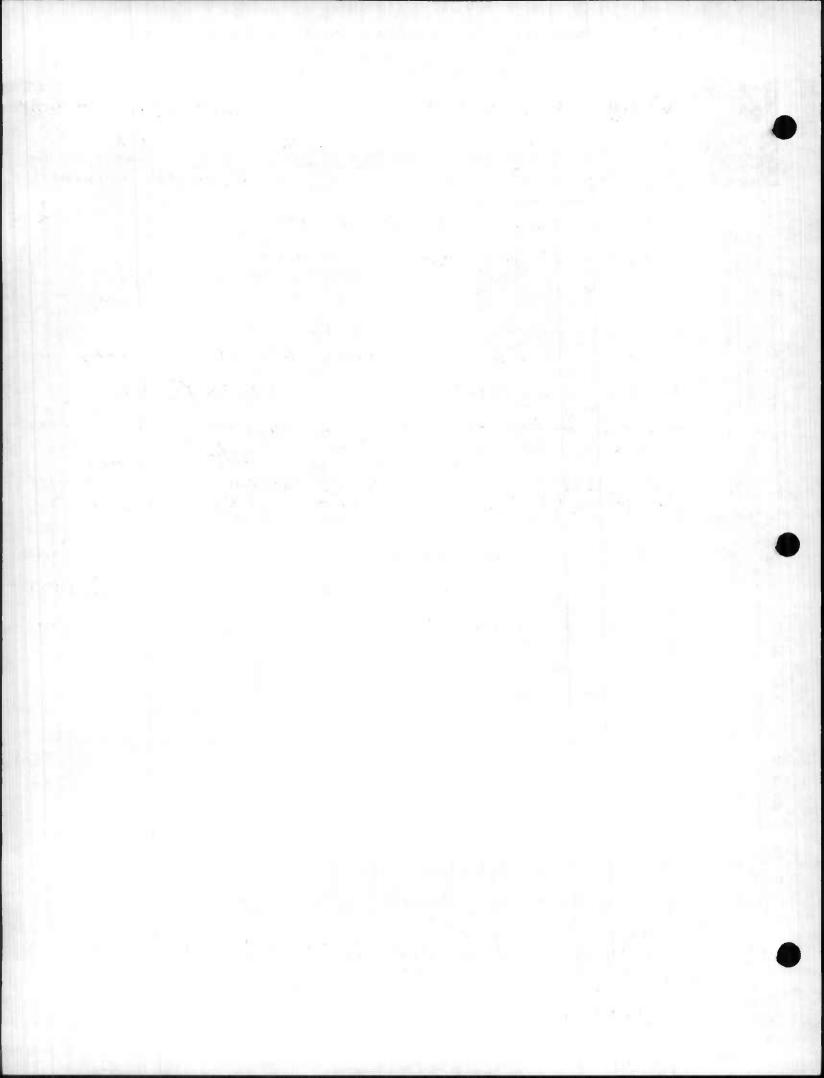
200 Memorial Ave.



State of Maryland / Department of Health and Mental Hygiene

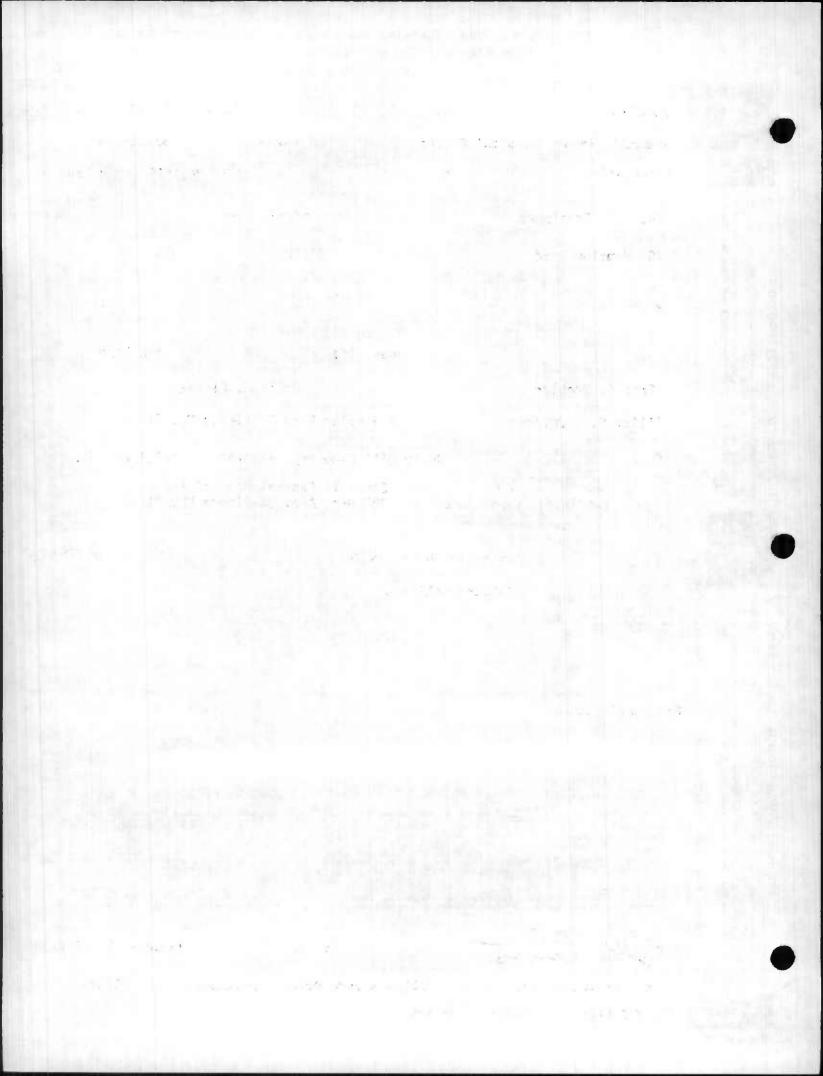
Certificate of Death 1. Decedent'a Neme (First, Middla, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** argaret JANUARY 4130 AM 27,1998 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Samaritan nospital Good BALTO Md If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months 1 M 28 F Yrs. **Director** 214-12-0422 July 26 1922 MARYLANC Usual Residence of Decedent death with the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f shoredical Experiment result be notified at 1 ☐ Yes 2 No Director Md BULTIMORE BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? W///o Ugh by Po 12. Wes Dacedent Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Detes: 2825 Completed by Funeral USA Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, atc. Peges 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or item ury or other traumatic evant, its Mental at Examinating or other traumatic evant, its Mental at Examinating. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify: WHITE 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OFFICER ATTORNEY 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be LERDY PROCTER ELLEN FISCHER WILLAM 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, Steta, Zip Code) 19e. Informant's Name/Reletionship (Typa, Print) permit. Peges 1 and 2 Department of Health el Important: If Itam 27 Is any injury or other trat once. 2300 RELIANCE CT. IMPRETISUILLE MARJORIE HIMMEL 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremation 3 ☐ Removel from Stete 50 4 ☐ Donetion 5 ☐ Other (Specify) GREENMOUNT Cem. 22. Name end Address of Fecility
HAIRTIEY MI 21. Signeture of Funerel Service Licensee FUNERAL HARTLEY alle BALTO Md 7527 HARTORL 21234 23e. Pert1. Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Daath **Physician** 30 minutes /Medical Immediata Causa (Final Cardio Pul monary disaese or condition resulting in deeth) Examiner Examine Intra Crunial Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest Dua to (or as e consequence of): tumo Box 68760. rain Physician/Medical Hospital or Attanding Physician: The law requires that the death certificate it Anours efter death. 24 hours efter death. Funeral Director: After this certificate hes been signed by the ettending physis the Due to (or as a consequenca of) P.O. signed by the end to Part II. Other eignificent conditions contributing to death but not rasulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, by 24b. Were eutopsy findings eveileble prior to completion of causa of deeth? Completed 24a. Wes en eutopsy performed? page 2 s 2 1No 1 ☐ Yas 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only ona) 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 2 ER/Outpetient 3 DOA funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Streat and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours of To the Funeral D completely filled I 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of exeminetion end/or investigetion, in my opinion, death occurred et the time, dete end plece, end due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signeture and title of certifier 29d. Data signed (Month, Day, Year) 29c. Licansa number 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 5601 Loch Raven Boulevard M.D. NOLAN, 31. Dete filed (Month, Day, Yeer) 2. Registrar's Signature State JAN 3 0 1998 Registrar

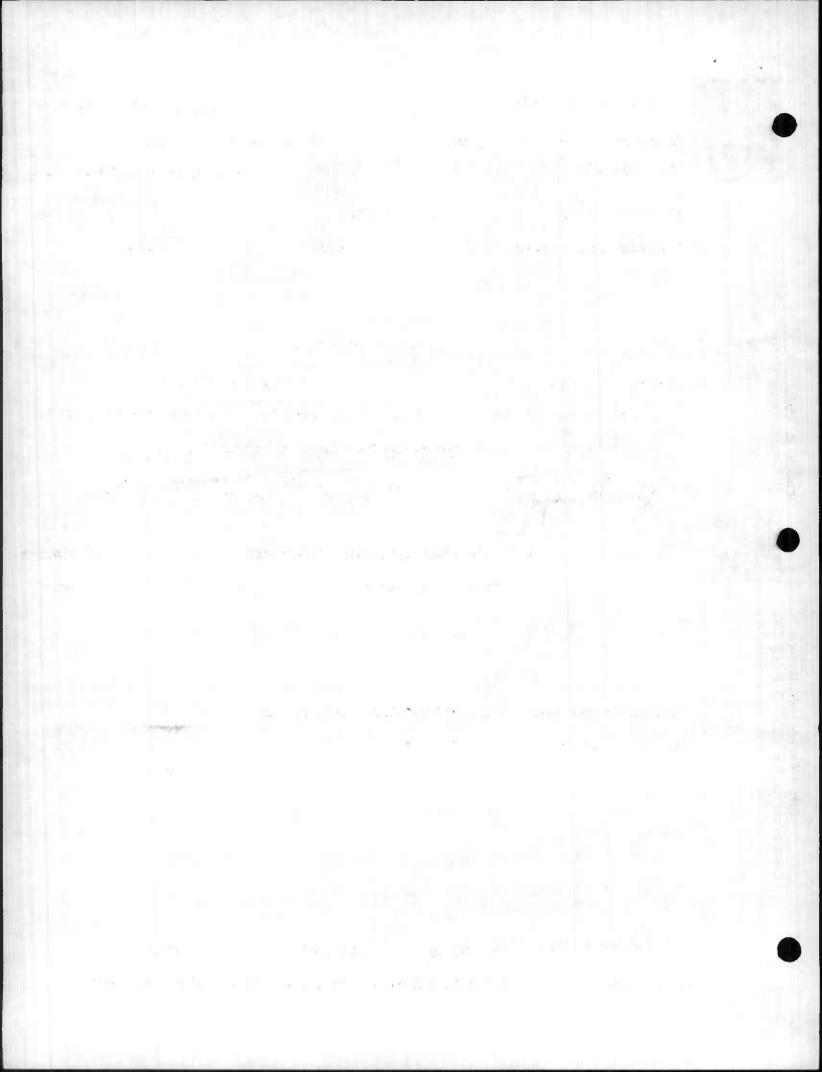


Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

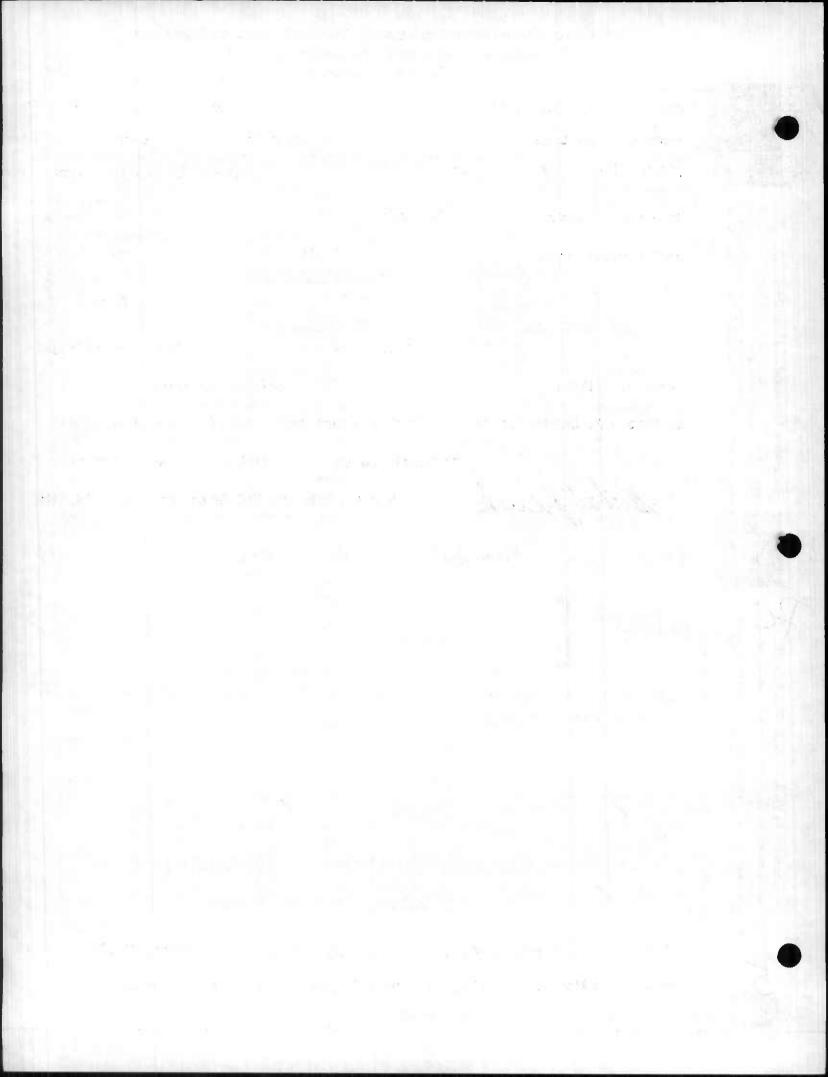
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		C.Ey Jr.									d. 2122		3000)	
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Robert Henry Filk 4a. Facility Nama (If not institution, giva Sunrise of Columb 5. Social Sacurity Number 046-05-1796 Usual Rasidance of Dacedant 10a. Stata 10b. County	street and number)				January	/ 29, 199	8 2:	4 5 4 4 4
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Maryland Howar		Town or Local					10d. Insida C	ity Limits
10e. Street and Number 6500 Freetown Roa	d		10f. Zip Coda 21	.044	10	0g. Citizen of Wha	t Country? JSA	
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/Medi Exami	cal	4e. Facility Nama (If not institut	ion, give street and nu	ımber)			4b. City. Town.	or Location of Dea	28	98 ty of Death	8 AN
Exami	iei	2335 Norfolk					Baltim	ore	N		
Funeral Director		5. Social Sacurity Number 220-12-776.	6. Sex	7. Aga (In yrs. las	st birthday) Yrs.	If Under 1 Yaar Months Days		Hrs. 8. Data of B Min. (Month, D 03-0	Sirth Day, Year) 7-23	9. Birthplace Country) NC	(Stata or Foraign
and *		Usual Residence of Decadant 10a. State 10b. Cour	tv	10c. City.	Town or Lo	cation				104	Insida City Limits
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should and Men is marked	Ť	19a. Informant's Name/Ralatio	nship (Type, Print)			g Address (Street					de) 21229
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permit. Pege Department of Important: If any injury or once.		21. Signature of Funeral Service	e Licensee					Baltimo			
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Physician		shock, or haart fallura. Li								On	arval Batwaan Isat end Death
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aftar death. Director: A I in by the fu	Ifica	3 ☐ Suicida 6 ☐ Coul	mined 208. Place	a of Injury - At home	e, farm, stre	eat, factory, offica			(Streat and Nun	nber or Rural Ro	oute Number,
aftar i Direct	Certification:	4 Homicide	build	ing, etc." (Specify)				City or T	own, Stata)		
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within 2 To the comple	M	29b. Signature and title of certif	iar	1 .		29c. Licens	se numbar		29d. Data sign	ad (Month, Day	, Yaar)
14.		Marina	xim	chun	/	0	421	96	Jan no	m 29	1,1998
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State Registrar

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4.		1. Decedent's Name (First,					Certificate			2. Dete of De	eth		3. Time of Deeth
Physician /Medical	_	Gleri	a Anı	ne Grace	•					Januar	y 30, 1	998	7:30
Examiner	ľ	4a. Facility Name (If not instant)		ve street and nu Chapel 1					4b. City, Town, or L Reisters			of Deeth	e
Funeral Director	-	5. Sociel Security Number 213–32–4965		Sex 1□M 2 T F	7. Age	(In yrs. last bir	thday) If Under Yrs. Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De Feb. 5	y, Yeer)	Coun	ece (State or Fore try) Land
ž	-	Usual Residence of Decede 10e. Stete 10b. C				10c. City, Tow	n or Location					10	Od. fnside City Lim
Tor Tor			ltimo	ore		Re	istersto	wn					1 Yes 2
in be notified		10e. Street and Number 226 Ar	ms Cl	napel Ro	bad		10f. Zip		1136		10g. Citizen of U.S		try?
Examiner must		11. Marital Status 1 □ Never Married 2□ 3 ☑ Widowed 4 □ Div		12. Wes Dec Armed For 1 Tyes If Yes, Gi Yeer or D	orces? 2 N ive		13. Was Deced		Hispenic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Ricen, etc.)		ce - Americ ck, White, e	etc.
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har tre		Mary Franc	es Ga	askin ^I	Daug				il, Carro				
Important: If Item 27 I any injury or other tri once.	1	20a. Method of Disposition 1 ☐ urlal 2 ☐ Creme 4 ☐ Donetion 5 ☐ Oth			State	cemeter	Disposition (Namy, crematory or of	ther pla	ardens, F	eb. 2,1	20c. Location		
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After this certificate funeral director, pag		25. Wes case referred to mexaminer? 1 ☐ Yes 27. Menner of Death		28e. Dete	Inpatier of Injury	28b. 1		A Oth	4 Li Nursing Ho	ome 50 resi		ner (Specify)
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Tothe		29b. Signeture end title of c	ertifier	and men	ner stat	le r		_	se number 5398		29d. Date signe	od (Month, I	Dey, Year) 1998
15	;	30. Name and address of pe	rson who	completed cau	se of de	eth (Item 23a) (0	1. Westr	ninster	JAN,	2115	7
State Registrar		31. Dete filed (Month, Day,	Year)	gulia 32	Regiotra Dav	r's Signatur			70201				

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Items: 10d, 18 per FH G-756 2/10/98 dh 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Month 11:00am CHARLES GUTRIDGE 27 1998 D. JAN. 4a. Facility Nama (If not Institution, give straat and number, 4b. City, Town, or Location of Daath 4c. County of Daath 1441 South Bonsa1 Street Baltimore Baltimore | B Q 1 C 1 H | S | S | Data of Birth | Months | Deys | Hours | Min. | Sept | 1 5. Social Sacurity Number 9. Birthplaca (Stata or Foreign Country) Maryland 7. Aga (In yrs. last birthday) 1€ M 2□ F 34 Yrs. 220-94-9053 Usual Rasidance of Dacedan 10a Stata 10h Count 10c. City, Town or Location 10d. Insida City Limits Md. Baltimore 1 (Yas 2 10 No Baltimore 10e. Street end Numbar 10f. Zip Coda 10g. Citizan of What Country? 1441 South Bonsal Street 21224 USA 14. Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedant Evar in U,S. Armad Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☒ No If Yas, Giva Yaer or Datas: 1 ☐ Yas 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Dacedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Dacedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Laborer 12th Construction 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Rita Woodrow Rita Withrow Charles Gutridge Sr. 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Steta, Zip Code) 7610 Gough Street Baltimore Md. 21224 Charlotte Loosemore/sister 20b. Place of Disposition (Name of cametary, cramatory or othar place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Holly Hill Cemetery 1/29/98 BAltimore MD. 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signeture of Funaral Sarvice Licensee 22. Nama and Address of Facility Connelly FuneralHome of Essex 23a. Parl 1. Entar tha disease, or complete that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, interval Batween conset and Death only of ecause on each line. Immediata Causa (Final disaasa or condition rasulting in deeth) Dua to (or as a consequence of): Malmetrition

Physician /Medical Examiner

> physician s the burin 88 for u ed by the a

been signer should be d

page 2

or Attending Physician: The law requires that the death certificete be est Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

Director

"naturel", or items 23a or 28a-f show

permit. Pages 1 end 2 should be filed within 72 hours affer c Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or item may Injury or other traumatic event, the Mexical Evanines. BARS.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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death

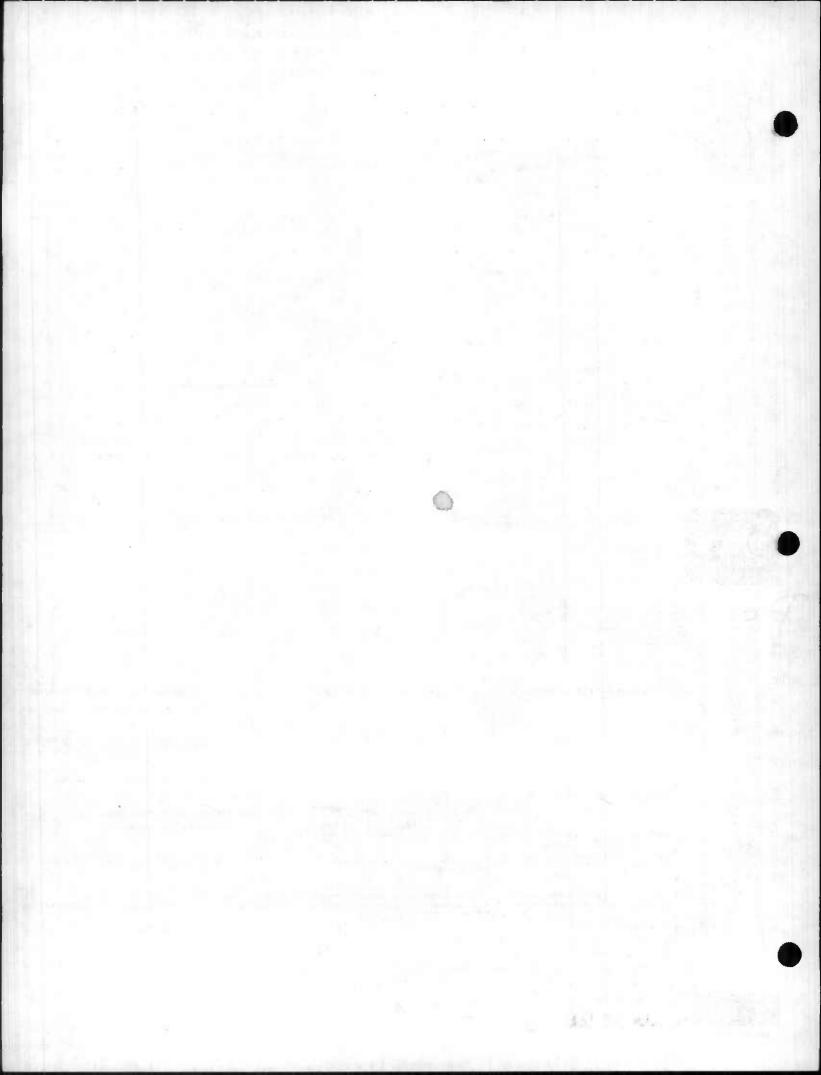
Sequentially list conditions, if any, leading to immediata causa. Enter Undarlying Ceuse (Disaasa or Injury that Initiated avants resulting In daath) Last	c. Omoric	or as a consequence of):	5		
Pert II. Other significant conditions co	entributing to death but not res	sulting In the undarlying ca	use givan In Part I.	23b. Did tobacco uee co	ontribute to the cause of death?
				24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to complation of cause of daath?
				1 □ Yas 2 DrNo	1□ Yas 2□No
25. Was casa refarred to medical exeminer?	Hospital: 1 Inpatient 2	ER/Outpatient 3 □ DO	Other	eeth (Check only ona) Homa 5☑ Rasidence 6 □ Ot	har (Specify)
27. Menner of Death 1 Natural 5 Panding 2 Accident invastigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	Bc. Injury et Work?	28d. Describe how Injury occu	
3 Suicida 6 Could not be detarmined	28e. Placa of Injury - At h building, etc. (Spaci	oma, farm, straat, factory,	office	28f. Location (Straat and Num City or Town, Stata)	ber or Rural Routa Number,
29a. Certifier (Check only one)	sician: To the best of my known of the basis of axamine and manger stated.	owledga, daath occurred a atlon end/or invastigation,	t tha tima, deta and place in my opinion, deeth occ	e, and dua to the causa(s) end mourred at the time, data and place,	annar as stated. end dua to tha cause(s)
29b. Signature and titla of certifier	20 M 41	290.	License number		ad (Month, Day, Yaar)

State Registrar

daath (Item 23a) (Type, Print)

To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral dir



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month WILLIE GREGORY 5:20 AM January 27 1998 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY 5. Social Security Number BALTIMORE If Under 24 Hrs. 8. Date NA OF MARYLAND MEDICAL SYSTEM If Under 1 Year 6. Sex / 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) A 12M 20 F Days Months Hours 229.18.5431 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE NIA MD 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 1700 21216 **HOMAS** VENUE 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use relied) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry S RD GRADE College (1-4or 5+) NA EMENT TINISHER ONSTRUCTION 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) SMITH ERNEST GREGORY JUJE 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) GREGORY BALTO LOTTIE 1900 THOMAS AVENUE MD. 20b. Place of Disposition (Name of cemetery, premetery or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State CEMETERY 1-31-98 BALTO. MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death NON-SMALL CELL LUNG CANCER Immediate Cause (Final month disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 FQ Yes 2 □ No 3 Probably 4 Unknown Metastatic PROSTATE CANCER 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en eutopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ■ inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year)

Physician /Medical Examiner

Examiner

Physician/Medicai

Completed

Certification: To

Medical

27. Manner of Death

1 Naturel

2 Accident

3 Suicide

29a. Certifier

4 Homlcide

(Check only one)

29b. Signature and title of certifier

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

items 23a or 28a-f el-

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Department of Important: If eny injury or once.

traumatic event, the Medical Examiner

Funeral Director

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Completed

the Marylend

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filed within 72 hours after death

21215-0020

Maryland

Baltimore,

Box 68760,

P.O.

Division of Vital Records,

permit.

cate hes been signed by page 2 should be detact

The law requires that the death certificate this certificate or Attending Physicien: funeral director. After

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun

State Registrar

5 Pending investigation

6 Could not be determined

29c. License number

28c. Injury at Work?

1st Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) end manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

28d. Describe how Injury occurred

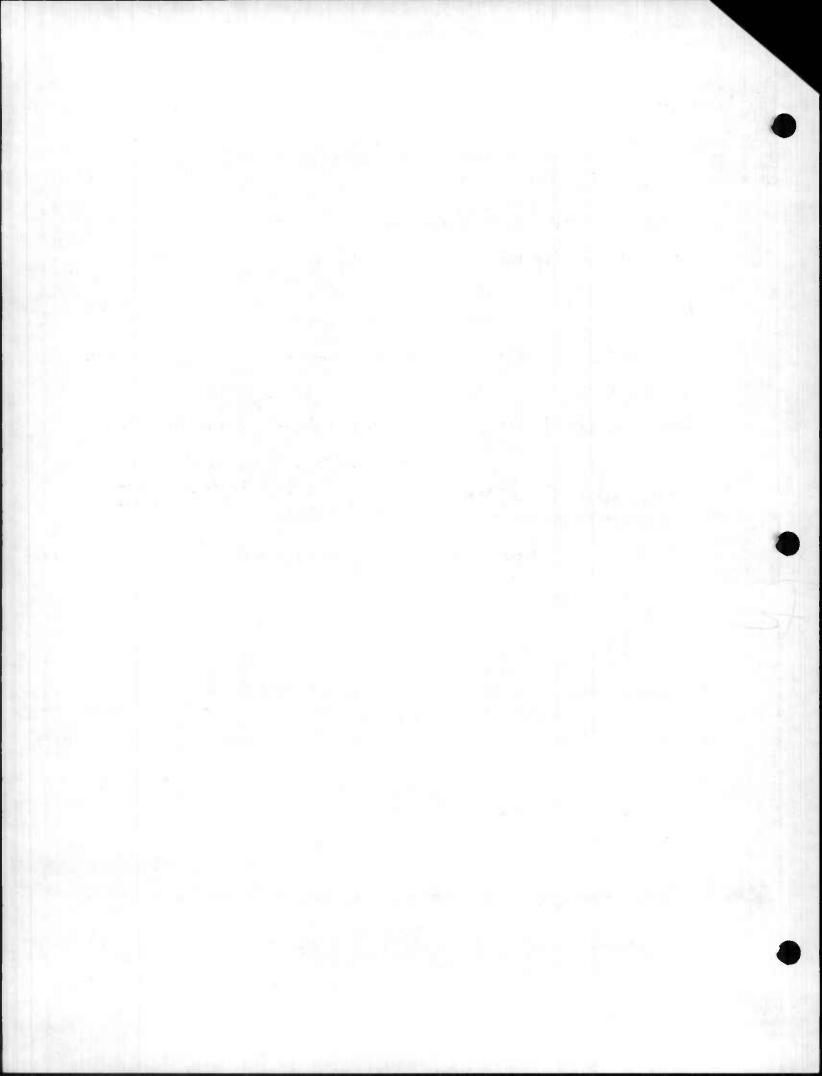
Univerysity of

Maryland Med System 22 5. Gerene St Baltimore, MD

31. Dete filed (Month, Day, Year) JAN 3 0 1998 32. Registrar's Signature Julia Savidson-Randell

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GRANT Month Day 28 1998 ROSSIE 1100 Hrs 4a. Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death RANDALLSTUWN BALTIMORE HOSPITAL NORTHWEST Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 8. Date of Birth (Month, Day, Year) 3-26-1935 Virginia 7. Age (In yrs. last birthday) **★**M 2□ F Months 227-40-9382 Yrs 62 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1₩ Yes 2□No Md. N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1100 Lynhurst St. 21229 USA 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. **Black** 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+)
2 yrs. Elementary/Secondary (0-12) 12 th Fork Lift Operator B. Green Food Inc. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Troy Grant Louiza Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delemetria Grant (Daughter) 1100 Lynhurst Street Balto., Md. 21229 20e. Method of Disposition
1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 20b. Place of Disposition (Name of cametery, crematory or other place) Dete 98 20c. Location - City or Town, State Arbutus Mem. Park Cem. 2-3 4 □ Donation 5 □ Other (Specify) Arbutus, Maryland 22. Name and Address of FacilityCaple Funeral Service 21. Signature of Funeral Service License 5502 Winner Ave. Balto., Md. 21215 Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequenca of) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? CIRRHOSIS, MYELOMA, HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? DIABETES, RENAL FAILURE 1 Yes 2 No 1 Yes ZU No 26. Plece of Deeth (Check only one) Hospital: 1 Enpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Physician

/Medical

Examiner

Director

Funerai

by

Completed

Funeral

Director

show

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I is marked othar than "natural", or items 23a or 28a-1 shov traumatic event, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 7 Depertment of Health and Mental Hyglene. Important: if Item 27 is marked other than "T any injury or other traumetic event, ma Motes.

Physician /Medical

Examine

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

Examiner Completed by Physician/Medicai

physician and the burial-transit al or Attending Physician: The safter death.
I Director: After this certificated in by the funeral director, pa hours a 24 hours Medical To the Hosp within 24 ho To the Fune complately f

25. Wes case referred to medical examiner?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) JANUARY 28, 1988

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

RAVI MD, NHC 1 BALTO. MD 21133

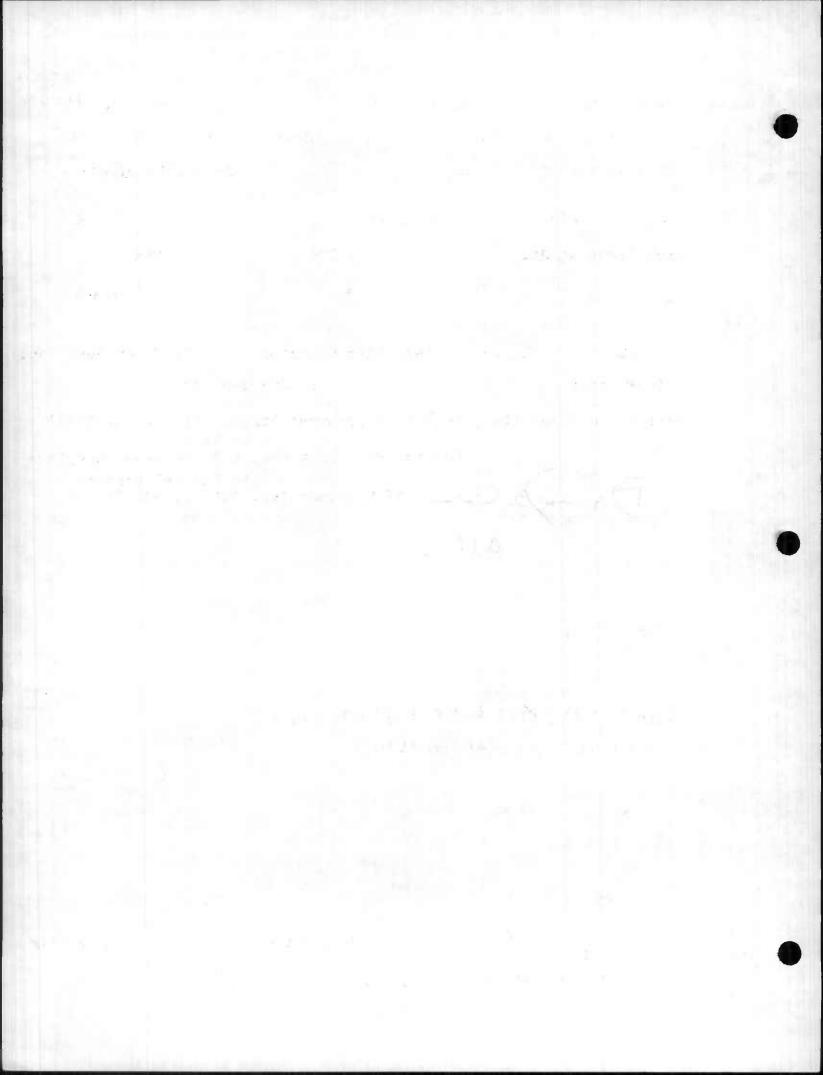
31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check only one)

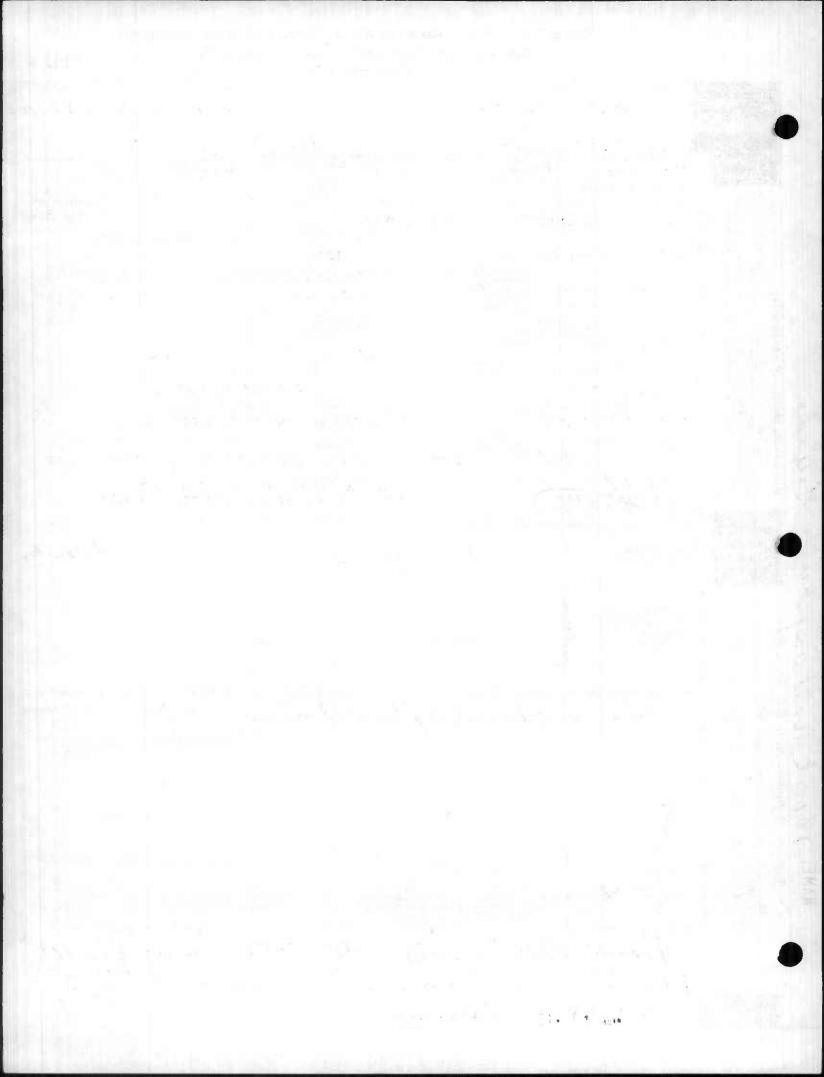
JAN 3 0 1998

32. Registrer's Signature Julia Davidson-Randelle



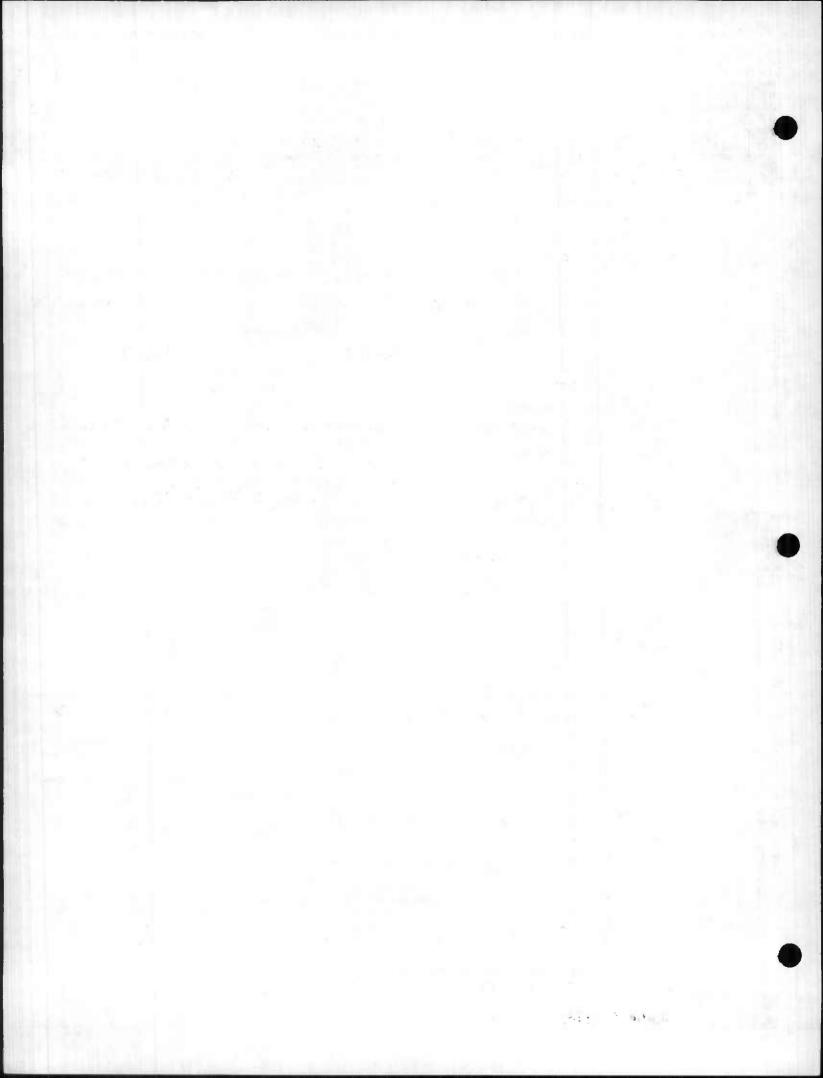
State of Maryland / Department of Health and Mental Hygiene Q

							.viai yiai				Death		Reg. No.	8 0	2410
		Physic	ian		ne (First, Middle, La							2. Dete of D Month	Dev	Yeer	3. Time of Deeth
		/Medi			THONY CHA							Janu		1998	0431/2
		Exami	ner	4e. Fecility Name	If not institution, give	1	J. O				4b. City, Town, or	Location of Dea	th 4c. Cou	inty of Deeth	
	3_		щ	5. Sociel Security I	lgnes 6. S	1405SI	ARC (In use	look bieth do	If I Inde	r 1 Year	If Under 24 Hrs	0 000	7	N/A	
		Funeral Director		213-51-2	432	M 2□ F	. Age (In yrs.	Yrs.	Months 4		Hours Min.		ay, Yee <i>r)</i> 1997	9. Birthp Cour MI	plece (State or Foreign htry)
		pue **		Usual Residence of 10e. Stete	10b. County		10c. Ci	ity, Town or	Location			<u> </u>		1	Od. Inside City Limits
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		ter death	ner	11. Mantal Stetus		12. Wes Deced	dent Ever in L	J,S. 13	. Was Dece		Hispenic Origin? (S en, Mexican, Puerl	pecify Yes or N	o- 14. F	Race - Americ	
	21215-0020	filed within 72 hours efter death with the Meryland Hygiene. ther than "natural", or flems 23s or 28s-f show ont, the Medical Exertines name to notified	by Fu	1 🖾 Never Man 3 □ Widowed	ried 2 Marrled 4 Divorcad	1 Tes 2 If Yes, Give	2 🔀 No				Specify:	o Hican, etc.)		Bleck, White, acify: WH	etc. ITE
	2-0	72 ho	ted	(\$00	15. Decedent's Ed	lucation		16e. Dec	edent's Usu	al Occup	petion during most of world)	rkina	16b. Kind o	f Business/In	dustry
	121	ne. hen r	Completed by	Elementary/Sec		College (1-	4or 5+)	life.			during most or wor	King	/-		
		Hygie thert nt, in	ပိ	17 Father's Name	(First, Middle, Last)				N/	A	18. Mother's Nar	no /Einst Middle	N/A		
	Maryland	a a a	Be	PAUL A.								LOUISE			
Q	2	s 1 end 2 should I Health end Men tem 27 is marke other traumatic	2		eme/Relationship (Type, Print)		19b. Me	ilina Addres	s (Street	end Number or Ru				Code)
X	×	end 2 salth er n 27 is			INDO/FATH						VE ROAD				
3	ē,	of Health item 27 i		20a. Method of Dis	position			Place of Disp cemetery, cr	position (Ne.	me of		Dete		on - City or To	
9	altimore,	Pages nent of int: If ite			☐ Cremation 3 ☐ 5 ☐ Other (Specify		tate	-	-		L GARDEN	1/28/9	8 MARRI	OTTSV	ILLE, MD
10	Balti	permit. Pages Department of I Important: If ite any Injury or of		21. Signature of 5	friend Service Licen	see		5	TERLI	NG A	ess of Fecility ASHTON FU				
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7		Physician	C		the disease, or compart failure. List only	one ceuse on ee	ch line.	an. Do not e	The the mo	io or dyn	ng, such es cardial	or respiratory	611631,		Intervel Between Onset end Deeth
3	7	/Medical Examiner		Immediete Ceuse diseese or condition resulting in deeth)	(Final on	θ.	as	pero	efer	W					4 months
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de	Bo	ethending for use	jan			u									
12	o	the d	Physician/N	Pert II. Other elgni	ficent conditions of	ontributing to dea	th but not res	sulting in the	underlying o	ause giv	ven in Pert I.	23b. Dio	tobacco uee	contribute to	the cause of death?
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0	ž.	requires that been signed b should be deta		,		0		0				24a. We	s en eutopsy formed?	24b. W	ere eutopsy findings eileble prior to
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2		After the	on:	27. Manner of Dee	5 Pending		Injury , Dey Year)	28b. Time Injury		28c. Inju		28d. Describe	how injury oc	curred	
(Sio	teetleetler:	cati	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be				М		Yes 2□No	001 1	10		10.
1E	Division	or At efter of Direct I in by	Certification:	4 Homicide	determined	200. P1000 0	of Injury - At h g, etc. <i>(Speci</i>	ify)	street, factor	у, опіса		City or To	own, Stete)	m <i>ber</i> or Hure	al Route Number,
NAME:	6	Tuning and a second	edical C	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	iner. On the bas	is of examine	owledge, dee	eth occurred	et the ti	me, date end pleca opinion, deeth occu	, end due to the irred et the lime	ceuse(s) end , date end plac	menner es s ce, end due to	teted. o the ceuse(s)
	(()	of the same	Med	29b. Signeture end	title of certifier	end menne	s stated.		29	c. Licens	se number		29d. Date sic	ned (Month,	Dev. Yeer)
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				30. Neme end add	num N	completed cause	of dooth fire	my	Prio*	DI	7000	11 1/20	tanu	ary:	16 1770
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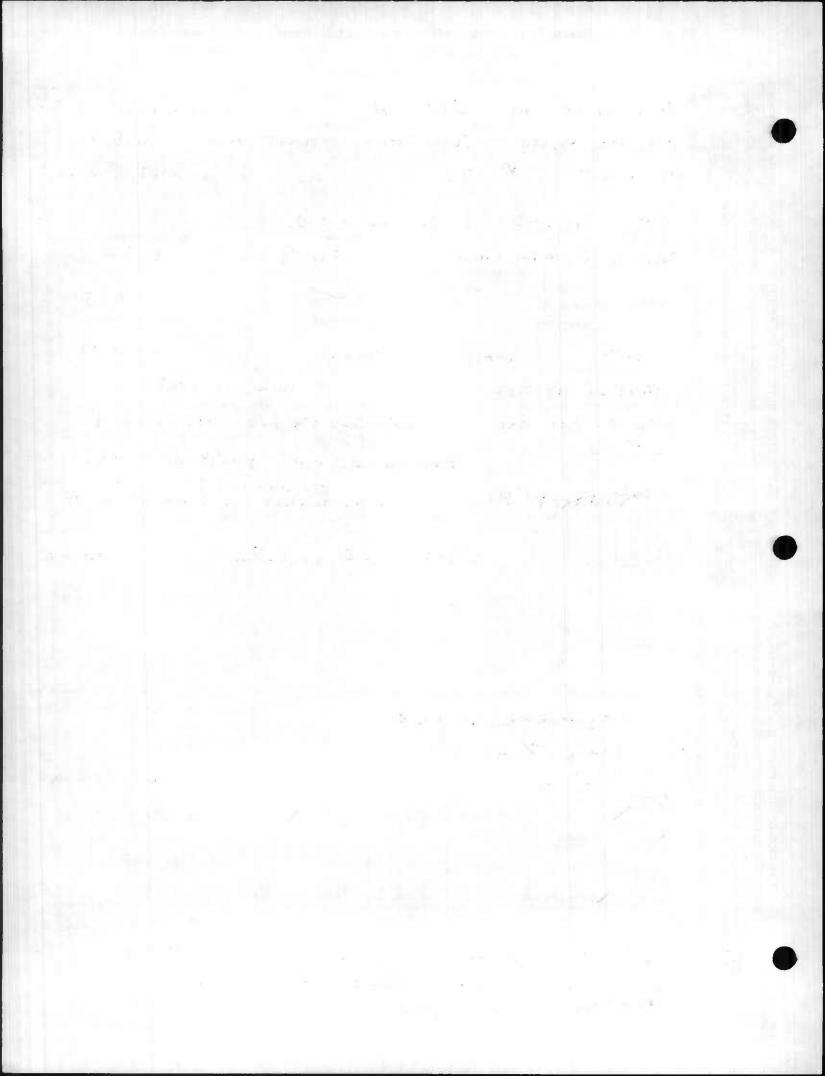
State of Maryland / Department of Health and Mental Hygiene

				Certifica				Reg. No. 8	021	11
Physic	cian	Decedant's Name (First, Middle, Las	•	1			2. Dete of De Month	eth Dey	Yeer	Time of Death
/Med		Lacy		aham			01	24 1	998	0302
Exam	iner	4a. Fecility Name (It) not institution, give	Hospital			4b. City, Town, or L		h 4c. County	of Deeth	
		5. Social Security Number 6. Se		(set hirthday) If Und	er 1 Year	Baltime If Under 24 Hrs.		th	0 Dishalasa	(Ctate or Fareign
Funera Directo			M 2□ F 72	Yrs. Months		Hours Min.	8. Date of Bir (Month, Da JUNE	,1925	N. CAR	(State or Foreign OLINA
yland		10e. Stete 10b. County	10c. Cit	y, Town or Location					10d. l	nside City Limits
the Marylar 28e-f show	to	MARYLAND	- E	BALTIMORE					1	Yes 2 No
th the	Director	10e. Street end Number			ip Code			10g. Citizen of V	Whet Country?	
th wi		730 EDGEWOOD STREE	T	2	1229			USA		
r des	Funeral	11. Marital Status	12. Wes Decedent Ever in U Anned Forces?	S. 13. Was Dec	edent of H ecify Cube	lispanic Origin? (Sp en, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Rac Bled	e - American Ir ck, White, etc.	ndien,
be filed within 72 hours after death with the Manyland niel Hygiene. Itel Hygiene hatural', or items 23a or 28a-1 show event, the Medical Exeminer must be notified at	by	1 ☐ Never Meπled 2 ☐ Maπled 3 ፟፟ Midowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Yeer or Detes: 43-4	1∏ Ves		Specify:				AMERICAN
d within 72 hours af giene, ir than "natural", or	Completed	15. Decedent's Edu (Specify only highest gred	ication le completed)	16e. Decedent's Us	uel Occup	etion during most of work	ina	16b. Kind of Bu	usiness/industr	у
within ene. than	mpidu	Etemantary/Secondary (0-12)	Coltaga (1-4or 5+)			during most of work	9			
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d 2 should be filed within the and Mental Hygiene. 7 is marked other than traumatic event, free.	Be	17. Fether's Neme (First, Middle, Last) FRED McDUFFY				18. Mothar's Nam			10)	
should and Men marke	2	19e. Informent's Name/Relationship (T	(me Print)	19b. Mailing Addre	es (Stroot		GAUS		State Zin Cod	(6)
2 9 8			DAUGHTERS	_		GATE ROA				
-1222		20a. Method of Disposition	20b. F	leca of Disposition (N	eme of		Dete	20c. Location -		
00		1 □XBurlel 2 □ Cremetion 3 □ F 4 □ Donetion 5 □ Other (Specify)	demover from Stete	RRISON FORE			/2/08	OWINGS	MTII N	4D
permit. Peges Department of Important: If it any injury or of		21. Signeture of Funeral Servica Licans							1111119 1	iu.
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Physician		shock, or heald feilure. List only o	na causa on aach lina.						Ons	ervel Between set end Deeth
/Medica		Immediate Ceuse (Final disease or condition	Marin	citis					/	5 days
Examine	9.1	rasulting in death)	eDue to (6	sitis	·):					5 days
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ifficate be executed g physician and as the buriel-transit	Examiner	Sequentielly list conditions,	U	r es e consequence of):					1
ficate be ext physician a ts the buriel	E E	Sequentielly list conditions, if eny, leeding to immediate ceuse. Entar Underlying Ceuse (Diseese or injury that initieted events							1	
ohysis	edicai	thet initieted events resulting in death) Lest	Due to (o	r es e consequence of):					
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eath cert attending	Physician/W									
at the de d by the	ysle	Pert II. Other eignificant conditions con			_					cause of death?
es that the igned by be detected		Congestive	Heart	- Failu	ne		1 🗆	Yes 2□ No	3 Probably	y 4 Denknown
The law requires that the death cert to hes been signed by the attendin page 2 should be deteched for use	d by	8					24a. Was	an autopsy	24b. Were e	utopsy findings
v require been sign	Completed							ormed?	eveilab	le prior to tion of cause
The law ate hes pege 2	dmo						4.0		of deeti	-1
		25. Wes case referred to medical						Yes 2□No	1 □ Ye	s 2DNo
sician: certific fractor.	o Be	examiner?	Hospital: Inpatient 2	ER/Outpetient 3 0	Oth Oth	er: A Nursing H		one) dence 6 □Oth	or (Engelfy)	
	, F	27. Manner of Death	28e. Dete of Injury	28b. Time of	28c. Injun Work			how injury occur		
The state of	ation	1 ☐ Natural 5 ☐ Panding investigation	(Month, Day Year)	Injury M		k? Yes 2 □ No				
or Attendant	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Pleca of Injury - At he building, etc. (Spacify	ome, ferm, street, facto	ry, office		28f. Location (City or To	Street end Numb wn, Stete)	per or Rurel Ro	ute Number,
Hospita 24 hours Furiara letaly fills	edicai C	29e. Cartifiar (Check only one) 2 Medical Exami	elclan: To the best of my kno ner: On the besis of exemine end mennar statad.	wledga, daath occurre tion end/or investigation	d at tha tin n, In my o	ne, data and plece, pinion, deeth occur	and dua to tha red et the tima,	causa(s) and ma date and place,	annar es steted and due to tha	ceuse(s)
within 2 To the comple	Me	29b. Signature and title/of certifier		2	9c. Licens			29d. Date signe	d (Month, pay,	Year)
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11		30. Name end eddress of person who co	omplated causa of daeth (Itam	23a) (Type, Print)		•		/	//	
			% MERCY HOSP		IMORE	E. MARYLA	ND 212	01	1	
	ate	31. Dete filed (Month, Day, Year)	32, Begistrer's Signe		17/17/					
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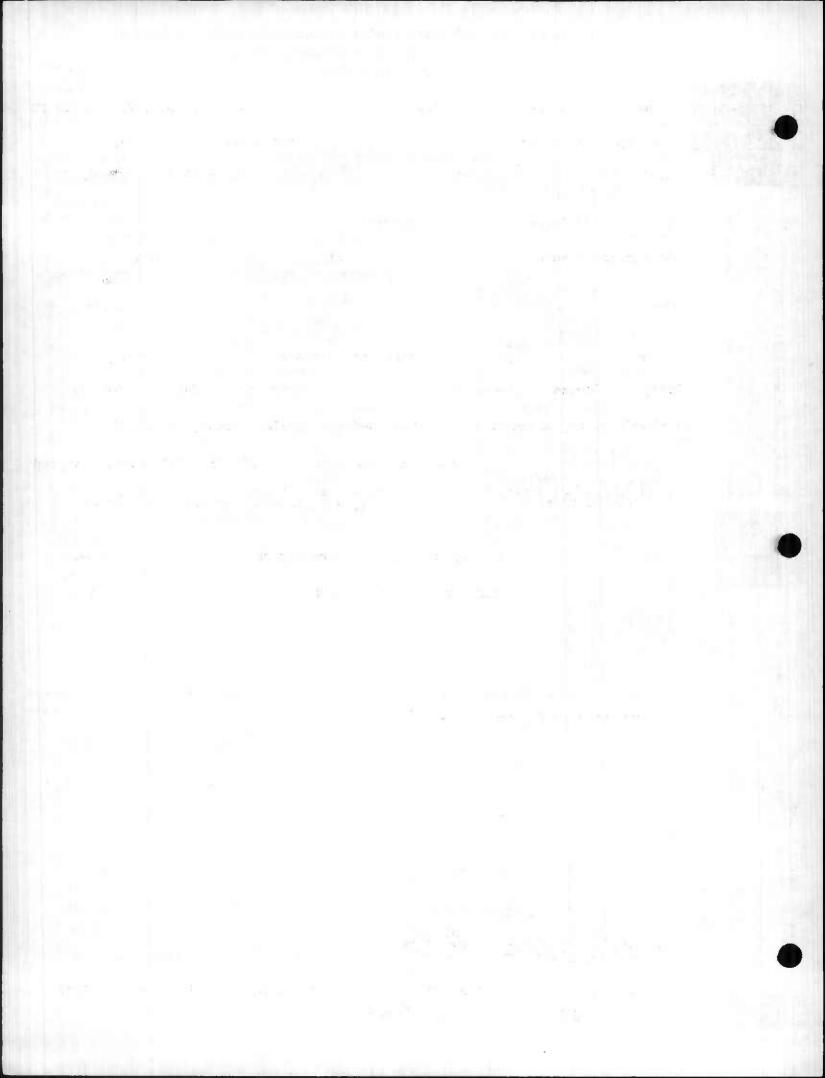
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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al al	5. Social Secu		6. Sax 7. A		est birthdey)	Undar 1 Yea			rth	9. Birthplace (State of Country)
r	218-03	ce of Decedent	1□ M 2√F	78	Yrs.	lonths Dey	s Hours Min	December	27,1919	MARYLAN
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l'e	10e. Street an	Number .				10f. Zip Code			10g. Citizen of V	Vhet Country?
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by Funeral Director		tus Married 2□ Merrie ved 4□ Divorced	12. Was Deceden Armed Forces d 1 Yes 2 fit Yes, Give Year or Dates	?			f Hispanic Origin? (suben, Mexican, Puer Specify:	Specify Yes or Note Rican, atc.)	o- 14. Race Blac Specify	a - Amarican Indian, ik, White, etc.
Be Completed by		15. Decedent's Specify only highest	Education grede completed)		16e. Deceden	i's Usuel Occ d of work dor	upation ne during most of wo	orking	16b. Kind of Bu	siness/Industry
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	14	t willer	Miller		7	597	Harford	RD. 8	ALTO. M.	21234
	23a. Pert1. E	nter the disease, or c	omplications that cause nly one ceuse on each	d tha daath	. Do not anter t					Approximet intervel Bet
ner	Immediate Ce disease or co resulting in de	ndition	е	Due to (or	es e consaque		Infac	Loi		LTW
i Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c.									
Medicai	thet initieted e resulting in de	vents	d	Due to (or	es e consequar	nce of):				
by Physician/N										
yslo	Part II. Other s	Ignificant condition	s contributing to death	but not resu	Iting in the unde	rlying causa	given in Pert I.	23b. Dic		ntribute to the cause
문	/	nagrae	sure	ure Denestia					1 Yes 2 No 3 Probably	
ò			Tule 24e. Wes an eutopperformed?						s an eutopsy formed?	24b. Were eutopsy available prior to completion of complet
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State of Maryland / Department of Health and Mental Hygiene Q

Anita Gunzelman Hines Jacob Johnson (Institution) provided and surface of the facility Name (Institution) provided and surface of the facility Name (Institution) provided and surface of the facility of the	cian		I. Decedent's Name (F	-irst, Middle, Las	st)						2. Date of Death		V	3. Time of Dea
As f. Facility Name given desirables, plus streets enry numbers S. Aques Hospital S. Save Security Name 10 Compy 1			Anita	Gui	nzelman	I	Hines				January	26 19	998	15:20 I
2 5. Sould Sourchy Number 2. See 2. Age (by yes, best brinday) 2. Mortal 10 to 10			e. Facility Name (If no	ot institution, give	street and num	nber)				4b. City, Town, or	Location of Death	4c. County	of Deeth	
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Security Security	i e	1	Ioe. Street and Numbe	or							10g. Citizen of What Country?			ntry?
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** HAPAIS 7:17 AM 26 YRONE /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA MEDICING SYSTEM BACTIMORE UNIVOF MARKHUD CITY if Undar 1 Yaar if Undar 24 Hrs. Hours Min. 5. Social Security Number 6. Sax 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Days Months 10 M 2□ F 220-76 -3717 38 Yrs. **Director** Oct. 10, 1959 Md. Usual Rasidance of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f ehow traumatic event, the Madical Examiner must be notified at n/a Md. Baltimore Yas 2 No Director 10a. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 1722 North Castle Street 21213 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "netural", or Itema 23a and Injury or other traumatic event, the Medical Examines must once. Funeral 12. Was Dacedant Evar in U.S. Armed Forcas? 11 Marital Status Was Decedant of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Navar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2XXXIo **Black** þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th Grade Contractor Leroy Ceaser 18. Mothar's Nama (First, Middla, Maiden Surnama) unknown 17. Fathar's Nama (First, Middla, Last) James Harris Amy Taylor Ward 19a. Informant's Name/Ralationship (Type, Print)mother 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 201 North Washington Street #406 Baltimore, mo. 21231 Amy Harris 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata A Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Dopation 5 □ Othar (Specify) Mt. Zion Cemetery Jan. 30 Baltimore, Md. 22. Nama and Addrass of Facility Nutter Funeral Homes, Inc. 21. Signatura of Funaral Service Licansaa 2501 Gwynns Falls PKWY Baltimore, Md. 23a. Part: Entar tife disaasa, or complications that odused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immadiata Causa (Final disaasa or condition resulting in deeth) SEASIS Examiner Dua to (or as a consequence of): Examiner AIDS physician and the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury Dua to (or as a consaguance of): Box 68760 CHRONIC KENTY FAILLIRE Physician/Medical that Initiated evants rasulting in death) Last Dua to (or as a consequence of): SE attending use for signed by the a P.O. Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, þ been si 24e. Wes an autopsy performed? 24b. Were autopsy findings availabla prior to complation of causa of death? Completed paga 2 has 2 X No 2 No certificata Division of Vital 25. Was casa referred to medical Be 26. Placa of Deeth (Check only ona) axaminar? Hospital: 1 Yas 2 No Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) 2 1 Monpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA this funeral 27. Manner of Death Hospital or Attending Pi 24 hours after daath.
 Funerel Director: After the 28b. Tima of 28c. Injury at Work? Certification: 28a. Data of injury (Month, Day Year) 28d. Dascriba how Injury occurred 1 Neturel 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, straet, factory, offica building, etc. (Spacify) in by 4 Homicida • Funerel I edlcai 29a. Cartifier 1 💯 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end place, and dua to tha ceuse(s) and menner es steted. (Check only 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) end manner stated.

29c. Licansa numbar

P 09764

New of Medicine ZZ S Greene St. Ba Himore MD

29d. Data signed (Month, Day, Year)

JAN. 26, 1998

21201

State Registrar

To the To the To the

29b. Signature and title of our lifer

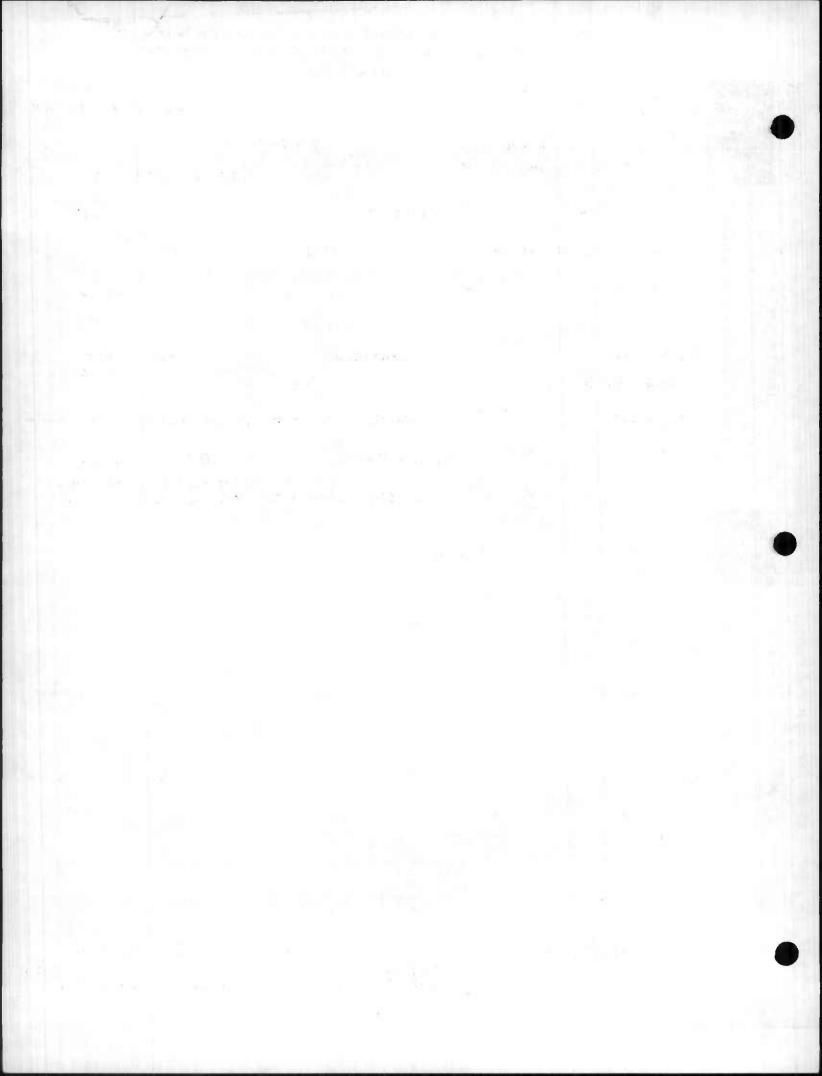
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THENER,

30. Nama and address of the son who complated ceuse of death (Itam 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item #18 per FH G756 2/3/98 EW Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Margarethe Hundert January 9:00 a.m. /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Baltimore City 3205 Rosekemp Avenue N/A if Undar 1 Yaar If Undar 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** 1□M 2X F Deys Hours 89 219-28-6635 Yrs. Director 1, 1908 Germany Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. inside City Limits tam 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event, tre Medical Examiner must be notified at Baltimore City 1 X Yes 2 No N/A Director Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 3205 Rosekemp Avenue United States Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Ricen, etc.) Race - American Indian, Black, Whita, atc. 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours effer c Depertment of Health end Mental Hygiene. Important: If Itam 27 is merked other than "natural", or Iten any Injury or other treumetic event 1 ☐ Yas 2 🗖 No If Yes, Give Year or Dates: 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: White Specify: by 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Administrative Hospital 12 17. Fether's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Johanna Hach Haack Johannes F. Moercke 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3205 Rosekemp Ave. Baltimore, Maryland Karl F. Hundert Jr. (Son) 21214 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 1 Bunal 2 □ Cremation 3 □ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Baltimore Maryland 2/3/98 21. Signatura of Funeral Service Licensee Milton J Knight Jr 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Pert1. Enter tha disease, or complications that capped shock, or heart failure. List only one ceuse on each the dean. Do not antar the mode of dying, such es cardiac or respiretory errast, Onsat and Death **Physician** Heart l'sease /Medical Immediata Causa (Final diseese or condition resulting in deeth) Examiner Physician/Medical Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): ettending 980 ö Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Donknown Ď 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificete 25. Wes case referred to person exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 1 Yes 2 Mo this 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funaral Director: After th completely filled in by the funera 28b. Time of 28c. injury at Work? Certification: 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) Mican) 30. Name end eddress of person who completed ceuse of deeth (Ilem 23e) (Type, Print) Dr. Gracito Patricio, M.D. 8903 Harford Rd. Baltimore, Maryland 2. Registrer's Signatura 31. Date filed (Month, Dey, Year) JAN 3 0 1998 Registrar

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	Physician		shock, or heart fai	lure. List o	nly one cause on	each line.				, g, caa. ac c					Interval Between Onset end Death
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Division	r Attender ter death rector:	ertification:	3 ☐ Suicide 6 4 ☐ Homlcide	Could no determin	200. PIOC	ea of Injury - At t	nome, farm, sti	eet, factory	, office			28f. Location (S City or Tow		ber or Run	al Route Number,
0	i Date	T I													

State Registrar

Medical (

29e. Certifier (Check only one)

29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 Dennis J - (V 31. Date filed (Month, Day, Yeer)



1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end placa, end due to the cause(s) end menner as steted.

**Chief Physician: To the best of my knowledge, death occurred et the time, date end placa, end due to the cause(s) end menner stated.

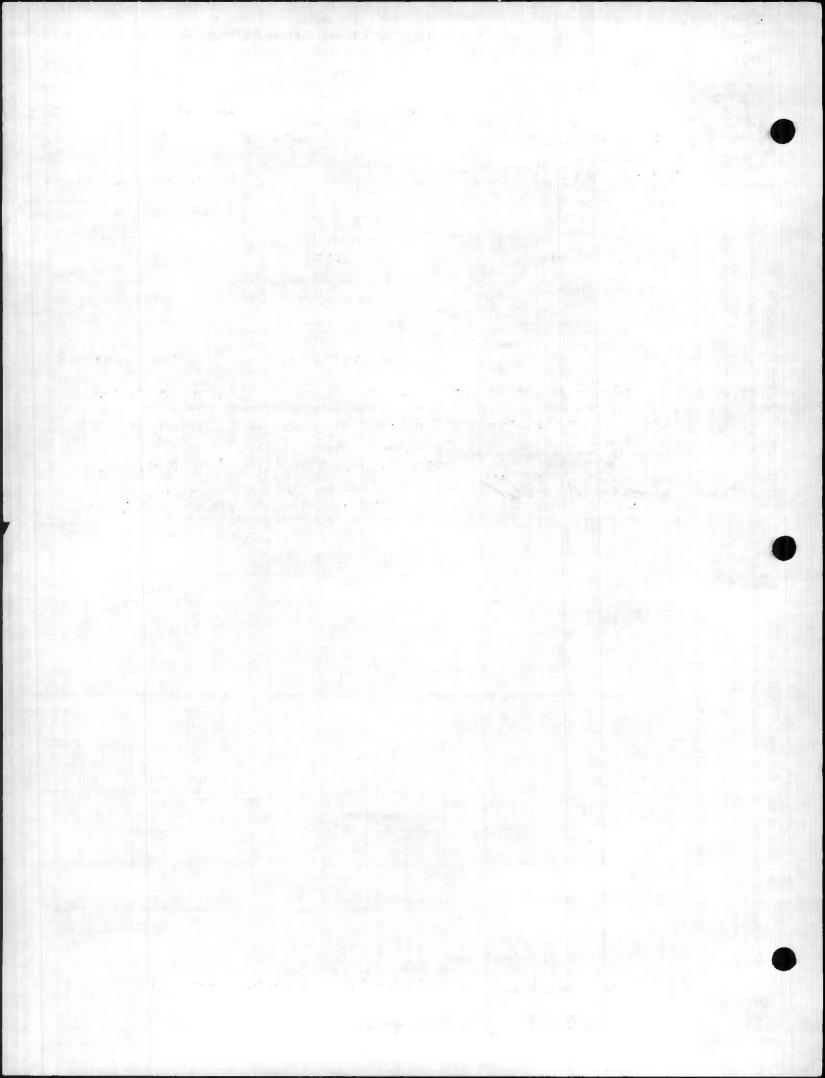
**Chief Physician: To the best of my knowledge, death occurred et the time, date end placa, end due to the cause(s) end menner stated. 29c. License number

O.C.M.E

29d. Date signed (Month, Dey, Year)

JAN. 27, 1998

DHMH 16 Rev 6/95



98-0270-510 * AM Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. CHARLIE State of Maryland / Department of Health and Mental Hygiene, HEMMINGWAY Item: 10e Per FH Film G-755 1-30-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day **Physician** CHARLIE HEMMINGWAY **JANUARY** 18,1998 0810 A /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner UNIVERSITY HOSPITAL O.R. If Under 1 Year 5. Sociel Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yeer) 9. Birthplace (Stete or Foreign Country) MD. 7. Age (In yrs. last birthdey) 6. Sex **Funeral** # M 2 F Months Deys Hours 27 Yrs. Director 217 80 1458 Usuel Residenca of Deceden the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "naturel", or items 23s or 28s-f show BALTIMORE 1#1 Yes 2 No Director N/A MD. 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? STRICKER ST. STOCKSTON ST. 21217 USA 1126 Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2# No If Yes, Give' Yeer or Dates: Race - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status Pages 1 and 2 should be filed within 72 hours after nent of Haaith and Mental Hygiene.
int: If Item 27 Is marked other than "naturel", or Ite Never Merried 2 Married SpecifAFRO AMERICAN 1 Yes 2 No Specify: 2 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE traumatic event. 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Lest) Be CHARLIE HEMMINGWAY SHIRLEY MOSES. 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) BALTIMORE, MD. 21217 1126 STOCKSTON ST. SHIRLEY MOSES MOTHER other Baltimore. 20b. Pleca of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State Injury or Depertment Important: If 4 ☐ Donetion 5 ☐ Other (Specify) ZION 1/24/98 | LANSDOWNE, MD. 21. Signature of Future Service Licensee 22. Name and Address of Fecility ESTEP BROTHERS FUNERAL HOME P.A 1300 EUTAW PL. BALTO. MD. 2121 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Examiner physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): 80 980 23b. Did tobacco uee contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 1 Yes 2 No 3 Probably 4 Unknown signed by by 24b. Were eutopsy findings eveitable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed cartificata has 1 Yes 2□No 2 No 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: X Inpatlent 2☐ ER/Outpetient 3☐ DOA 1X Yes 2□ No Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

Division of Vital Records,

2 funaral Certification:

27. Menner of Deeth

1 Naturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending

investigation

6 Could not be

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Attending death. ctor: D STO To the Hospital within 24 mores al

> State Registrar

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**Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete and placa, end due to the cause(s) end menner steted. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature end title of cartifier 29c. License number OCME JANUARY 19,1998 or de 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) THEODOPE Mikin

28b. Time of

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28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

1 Yes

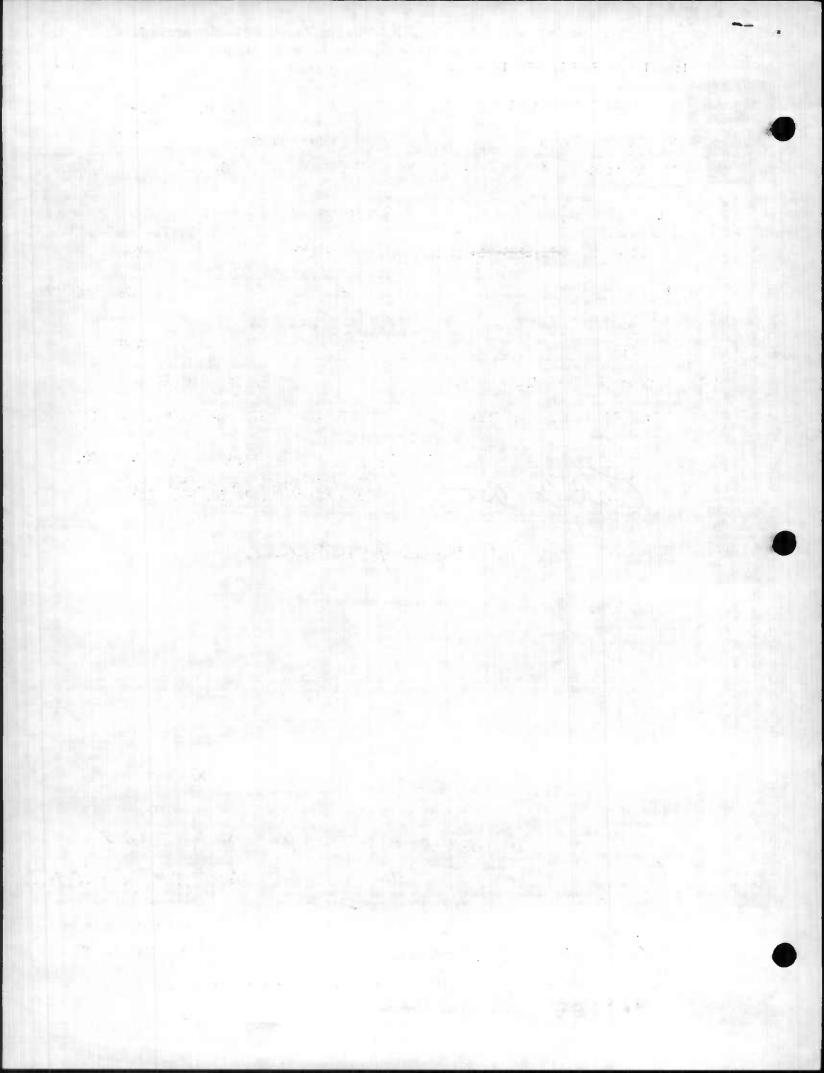
28d. Describe how injury occurred

ree

411 Penn Street, Baltimore, Maryland 21201 32 Registrar's Signature

28e. Date of Injury (Month, Dey Year)

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death Month Physician 10.10 Pm ELZIE LEROY HOOD, SR. 1998 JAN /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL NORTH ARUNDEL HOSPITAL GLEN BURNIE If Under 1 Year If Under 24 Hrs. 9. Birthplece (State or Foreign Country) USA 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** tX M 2□ F Months Days Hours 219-20-9364 Yrs. Director 70 9/14/27 Usual Residence of Decedent the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD ANNE ARUNDEL SEVERN 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1353 Raleigh Drive Funeral 21144 USA 12. Was Decadent Ever in U,S.
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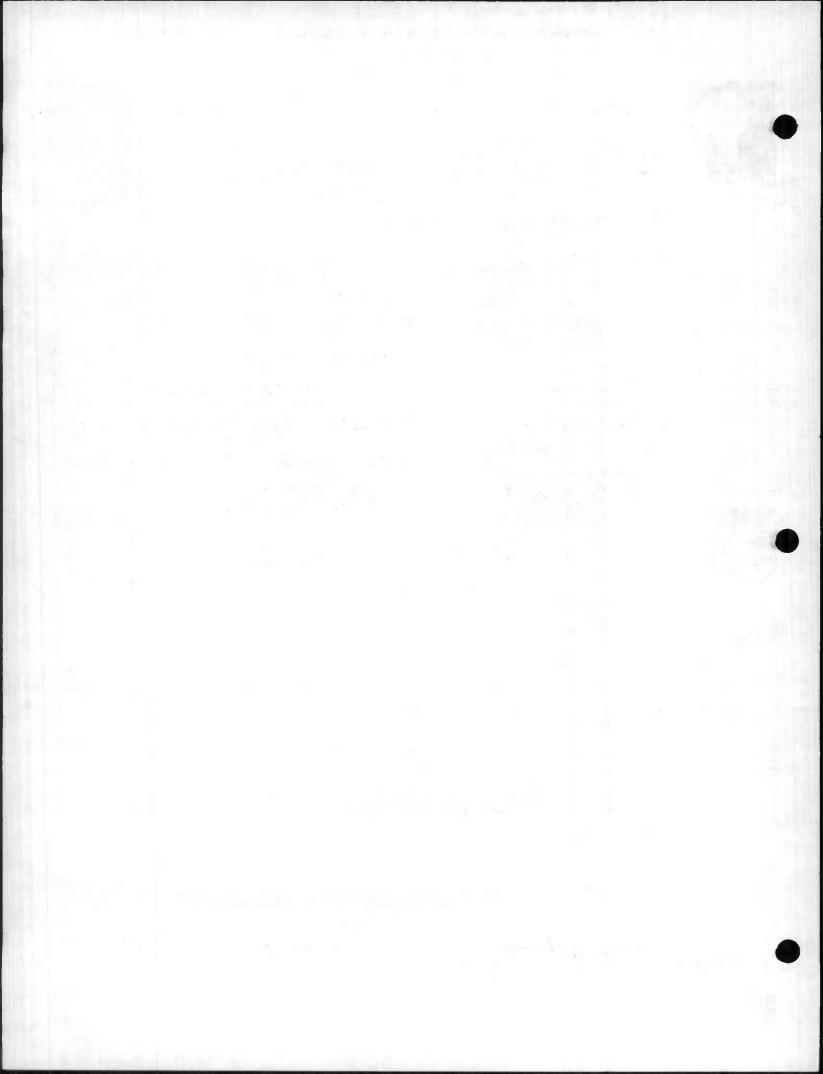
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1 Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White py 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " Elementery/Secondery (0-12) College (1-4or 5+) Heavy Equipment Mechanic/Foreman permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If Itam 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ASA HOOD CLARA MAY WHEELER 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VERA G. HOOD, Wife 1353 Raleigh Drive, Severn, MD 21144 f Disposition (Name of Date 20c. Location - City or Town, Stele 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Epiphany Cemetery 1/30/98 Odenton, MD 21. Signature of Ferrardi Service Licensee 22. Name end Address of Facility Hardesty Funeral Home, PA 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, list only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last and Due to (or as e consequenca of) Records, P.O. Box 68760. attending physician for use as the buna Physician/Medical Due to (or es a consequence of) signed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? page 2 should 24a. Wes en autopsy performed? Completed certificate has 1 Yes 2 No 1 ☐ Yes _2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 10 1 Yes 2 → NO 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner es steted. Medical 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 295. Signature/and title of certifier 29c. License number 29d. Date/signed (Month, Day, Year) /selex Neme and address of person who completed cause of death (Item 23e) (Type, Print) Gles Surie, MD 2106 7845 DAKWOUD ross 31. Date filed (Mor 32. Registrar's Signature chia Davidson Registrar



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Physicia: /Medica	_	 Decedent's Neme (First, Mide 	fle, Last)					2. Dete of De Month	eth Dey	Yeer	3. Time of Deeth
	_	MARIE	A.	HAY	55			JAN		1998	12:30 AA
Examine	-	4e. Fecility Neme (If not institution	on, give street and nu				4b. City, Town, or	Location of Deat	4c. County	of Death	
		HOWARD COUNTY	SENERAL HO	SPITAL			COLUM	BIA	HOW	ARD	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Ye	ar If Under 24 Hr	s. 8. Date of Bir		9. Birthpl	eca (Stete or Foreign
Director .		101-20-556 Usual Residence of Decedent	1□M 2 <u>M</u> F	70	Yrs.	Working	S FIOUS WITH		6, 1927	NEW	
show	.	10a. Stete 10b. Count	y	10c. City	, Town or Loca	ation				10	Od. Inside City Limits
28a-f shonouthing at		MARYLAND HOW	VARD		COLUMB				40-02:	10	1 ☐ Yes 2 📉 No
0 2 2						10f, Zip Code			10g. Citizen of \		try r
must a	era	6099 MAJOR LANI 11. Maritel Status		edent Ever in U,	S 13 W	as Decedent o	21045	Specify Yes or No		S.A. e - America	an Indian
0 5	by Funeral	1 Never Merried 2 Ma 3 Widowed 4 Divorca	Armed Fo	rces? 20 No		Yes, specify C	f Hispenic Origin? (i uben, Mexican, Pue o Specify:	rto Rican, etc.)	Specify Specify	ck, White, e	etc.
		15. Decade	nt's Education	1	16a. Decede	nt's Usuel Occ	upetion		16b. Kind of Bu	PLA: usiness/Ind	
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marked metic e		OSCAR SMITH					MARIE	MACCANON			
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N L		STANFORD HOYES	SON				ANE, COLU	MBIA, MA	RYLAND :	21045	
+ b		20e. Method of Disposition 1 ☐ Buriei 2 ☐ Cremetion	3 Removel from		laca of Disposi ame <i>tery</i> , crema	tion (Neme of story or other p	lece)	Dete	20c. Location -	City or To	wn, Stete
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been signed by the ettending should be deteched for use as	Dy ruysiciarum	resulting in deeth) Lest					·	1 🗆	Yes 2 No en eutopsy ormed?	3 Prob	the cause of death? ably 4 Unknown re autopsy findings ilable prior to noletion of cause
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month 1950hrs. JAN. 1998 MARIE E. HORTON 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death BALTIMORE ST. AGNES HOSPITAL 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) Months Deys Hours 1 M 20 F Yrs. 175-18-8225 JUL. 31, 1905 PENNSYLVANIA 10a. Stete 10b County 10c. City, Town or Location 10d. Inside City Limits MARYT AND BALTIMORE 1 Yes 2 No CATONSVILLE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1207 BIDDLE PLACE 21228 U.S.A. 11. Meritel Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 € No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 HOUSEKEEPER HEALTH CARE 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) RUDOLPH HAVEL MARGARET ZAPP 19e. Informent's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ROSS H. RESSLER JR., NEPHEW 1207 BIDDLE PLACE, CATONSVILLE, MARYLAND 21228 20a. Method of Disposition 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State IMMACULATE CONCEPTION 1/30/98 JOHNSTOWN, PA 15906 4 ☐ Donetion 5 ☐ Other (Specify) CEMETERY
22. Name end Address of Fecility WITZKE FUNERAL HOMES, INC. 21. Signature of Funeral Service Licensee Ca. 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death PNEUMONIA Immediete Ceuse (Finel disease or condition resulting in death) Approx. 10 days Due to (or es e consequenca of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events resulting In death) Last Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CORONARY ARTERY DISEASE 24b. Were eutopsy findings eveileble prior to completion of cause of death? HYPERTENSION 24e. Wes en eutopsy MALNUTRITION 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No

/Medical Examiner buriel-transit the attending physician hed for use as the burie signed by to

P.O. Box 68760.

Physician

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

nem 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner mast be notified at

with the Maryland

hours efter

illed within 73 i Hygiene. other than "na

permit. Pages 1 and 2 should be filed Department of Health and Mentel Hygid Important: If item 27 is marked other i any injury or other traumatic event.

Baltimore, Maryland 21215-0020

peen After this certificate hes death.

Physician/Medical Be 2 Certification:

after death Director:

Examiner by Completed 27. Menner of Deeth Medical 29a. Certifier

1 Naturel

2 Accident

4 Homicide

(Check only one)

29b. Signetum a

3 ☐ Suicide

Division of Vital Records, To the Hospital within 24 hours a To the Funeral C

> State Registrar

Utle of certifier MEDICAL RESIDENT 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

28a. Dete of Injury (Month, Dey Year)

29c. License number

28c. Injury et Work?

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

5 Pending investigation

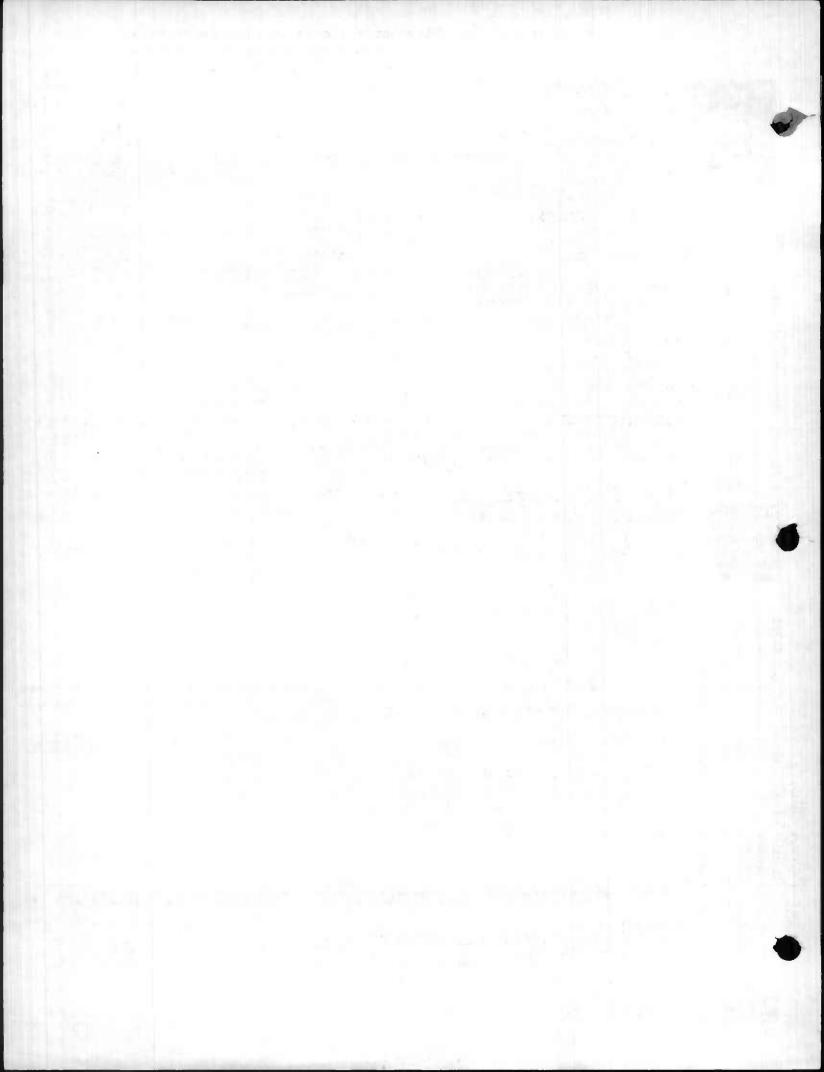
6 Could not be determined

CHARLES C. MBONU, 900 CATON AVE BALTO 31. Date filed (Month, Day, Yeer)

28b. Time of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

92. Registrar's Signeture who Davidson Mandall. JAN 3 0 1998



BALTIMORE, MARYLAND 21215-0020 nours after death. Page 6 may be retained by the hospital or attending physician TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crema iMPORTANT: If Hem 28 is marked, or Hem 23 shows any Injury, or other traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	the attending physician and completely filled in by the funeral di Mental Hygiene prior to burial, cremation, or removal.	matic event, the medical examiner must be notified at
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	r this certificate has been signed by the a th with the State Oept, of Health and Meni	narked, or Item 23 shows any injury, or other traumatic
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	1 - FOR STATE REGISTRAR Item#4 per F	STATE OF MARYLA H G756 2/3/98 E	ND / DEPARTM	MENT OF H	EALTH AND DEATH	MENTAL HYGIEN	IE .	02421				
	1. DECEDENT'S NAME (First, Middle, Last)	sch				2. DATE OF DEATH		YEAR 550 AM M				
	050-01-9489	6. AGE (In		UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE DF BIRTH (Month, Day, Year)	// 8	BIRTHPLACE (State or Foreign Country) New YORK				
TOR	90. FACILITY NAME (If not institution, give street and number) Vantage House 5400 Vantage Point Ale Columbia Hd. 21044 Howard RESIDENCE OF DECEDENT											
DIRECTOR	10a. STATE 10b. COUNTY	Howard	10c. CITY, T	OWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL	100. STREET AND NUMBER 5400 Vantage;	Point Rend			ZIP CODE	44		N OF WHAT COUNTRY?				
BY FUN	3 Wildowed 4 Divorced IF YES, GIVE WAR DR OATES 1 YES 2 ND Specify:							RACE — American Indian, Black, White, etc.				
TED	16. DECEDENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY											
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+) life. Do NOT use retired.) Secretary medical											
) BE	19a. INFORMANT'S NAME (Type/Print)	- 11	19b. MAILING AD	DRESS (Street a								
۲	198. INFORMANT'S NAME (Type/Print) 199. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 245-06 62 Ave., Douglaston, N.Y. 11362											
	20a, METHOD OF DISPOSITION 1 D' Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory, or other piece) Beth David 1/30/98 Elmont, N. Y.							y or Town, State				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Witzke Funeral HOmes, Inc. 21045 5555 Twin Knolls Rd., Columbia, MI											
	23. PART I. Enter the diseases, or con ahock, or heart fellure. Lia	nplications that ceused to only one ceuse on each	the death. Do not th line.	enter the mo	de of dyling, suc	h as cardlec or reap	ratory arrest	t, Approximets				
	IMMEDIATE CAUSE (Final disease or condition resulting in desth)	Coron	any F	Frtz	ery ?	Diseas	se	Onset and Death				
2	Conventiolly, lies and distance b.	DUE TO (DR AS A C	CONSEDUENCE OF):					7.				
ATIC	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	OUE TO (DR AS A C	CONSEDUENCE DF):									
CERTIFICATION	CAUSE (Disease or Injury thet initieted events resulting in death) LAST	OUE TO (OR AS A C	CONSEDUENCE DF):									
CER	d											
CAL	PART II. Other significant conditions of	ontributing to deeth but	not resulting in ti	ne underlying	cause given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO				
MEDIC	Typerich					1 YES 2	ND	COMPLETION OF CAUSE OF OEATH?				
	DID TOBACCO USE CONTRIB				UNCERTAIN	V 🗆						
PHYSICIAN:		OSPITAL:	B. PLACE DF DEATN (C	HER:								
H	27, MANNER OF DEATN	28a. DATE DF INJURY	28b. TIME OF	28c. INJL	JRY AT	8 Other (Specify) 28d. DESCRIBE NOW II	NJURY OCCUR	RED				
8Y F	1 Natural 5 Pending Investigation	(Month, Day, Year)	INJURY		ES 2 ND							
	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY — building, atc. (Specify	- At home, farm, stree)	t, tactory, offica		281. LOCATION (Street a City or Town, State)	nd Number or i	Rural Route Number,				
COMPLETED		N: To the best of my knowled on the bests of examination s						euse(s) and manner as stated.				
O BE C	29b. SIGNATURE AND STILL OF GENERAL	Tice, m	1.0.		29c LICENSE NUM 0507	778	29d. DATE SI	1 28 1995				
	MICHELLE PRI	CF 11055	Little Par	uxent	PKWY	St 205 (Blumi	but, Mp 21044				
1 1	31. DATE FILED_(Month Day Year)	32 REGISTRAM'S SIGNATION	URE		1							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item #8 per FH G756 2/3/98 EW Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month **JANUARY** OTTO P. HIRSCH 27, 1998 8:55PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** CHARLESTOWN RETIREMENT CENTER BALTIMORE BALTIMORE If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Deys Months MM 2□ F Director Yrs APR.19, 1915 215-01-4957 82 MARYLAND Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28a-f sho traumatic event, the Medical Examinar must be rictified at Director MARYLAND BALTIMORE CATONSVILLE 1 ☐ Yes XXNo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? death with Completed by Funeral U.S.A. 707 MAIDEN CHOICE LANE, APT. 3408 21228 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. filed within 72 hours efter 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 21215-0020 1 ☐ Yes 2√2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grede complated) 16b. Kind of Business/Industry ai Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) SPARE PARTS TECHNICIAN WESTINGHOUSE Baltimore, Maryland 17. Fether's Name (First, Middle, Lest) . Pages 1 and 2 should be file ment of Health and Mantal H lant; if Itam 27 Is marked oth jury or other traumatic even 18. Mother's Name (First, Middle, Melden Surneme) Be 2 CURT H. HIRSCH HELENE UHLICH 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 707 MAIDEN CHOICE LANE, APT3408, CATONSVILLE, MD 21228 VERA A. HIRSCH, WIFE 20b. Plece of Disposition (Nema of cemetary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) LOUDON PARK CEMETERY 1/30/98 BALTIMORE, MARYLAND 21. Signeture of Fundamental Service Licensee 22. Name end Address of Fecility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on agent line. **Physician** /Medical PNEUMONIA Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Due to (or es e consequenca of): Examiner The law requires that the death certificeta be axecuted Sequentially list conditions, if eny, laeding to immediate causa. Enter Underlying Cause (Diseesa or injury that initiated events resulting in deeth) Lest the buriel-tran Due to (or es e consequença of): P.O. Box 68760, been signed by the ettending physician should be detached for use as the burie Physician/Medicai Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Records, þ Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings evellable prior to completion of cause of deeth? has i After this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No IAGETES Division of Vital Attending Physician: Be director 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 ☐ Rasidanca 6 ☐ Other (Specify) Certification: To 1 Yes 2 No funeral 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 PNaturel 5 Pending investigation death. 1 ☐ Yas 2 ☐ No 2 Accident after death filled in by tha 3 Suicide 6 Could not be datamined 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 4 Homicide 8 To the Hospital within 24 hours a To the Funeral Complataly filled 1 Certifying Phyeician: To the best of my knowladge, deeth occurred at the time, data end place, and due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et tha tima, dete end placa, and dua to the ceusa(s) and menner stated. 29e. Certifian Medical (Check only one) 29b. Signeture endrtitle of cartifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

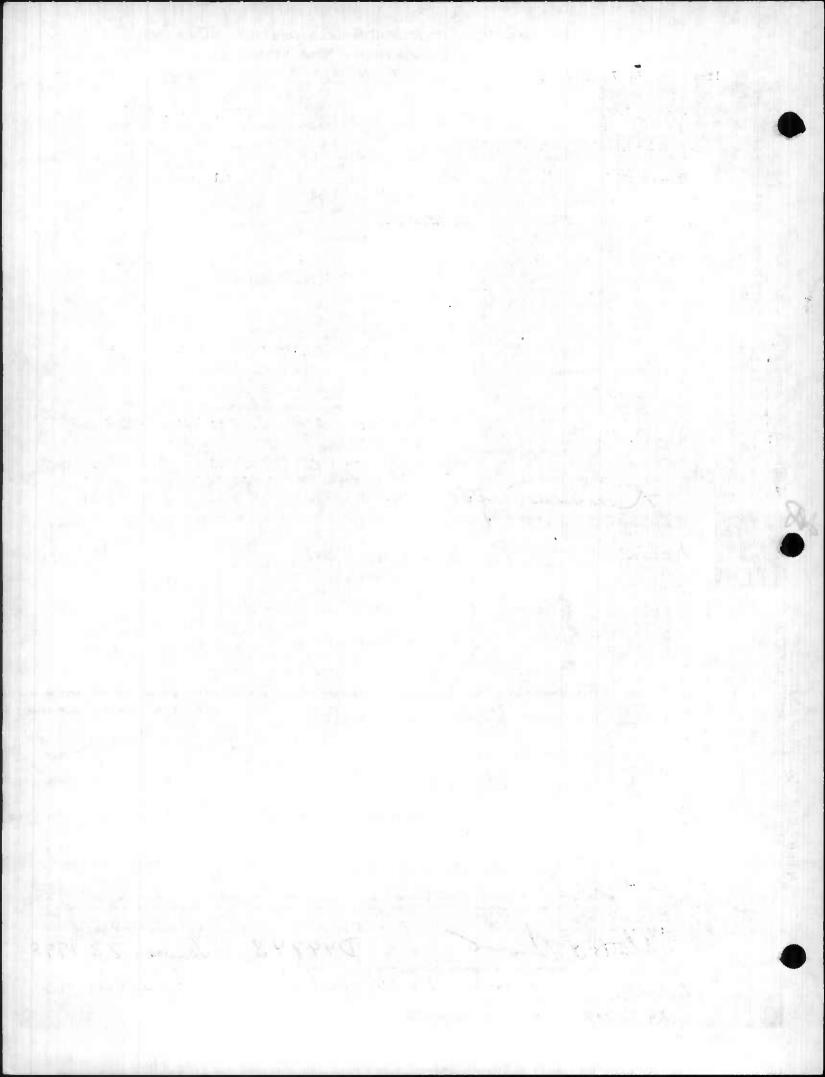
TTNEW 31. Dete filed (Month, Dey, Year) JAN 3 0 1998

32. Registrer's Signeture Deviden.

VARRETT

MAIDEN CHOICE LANE CATONSVILLE, MD

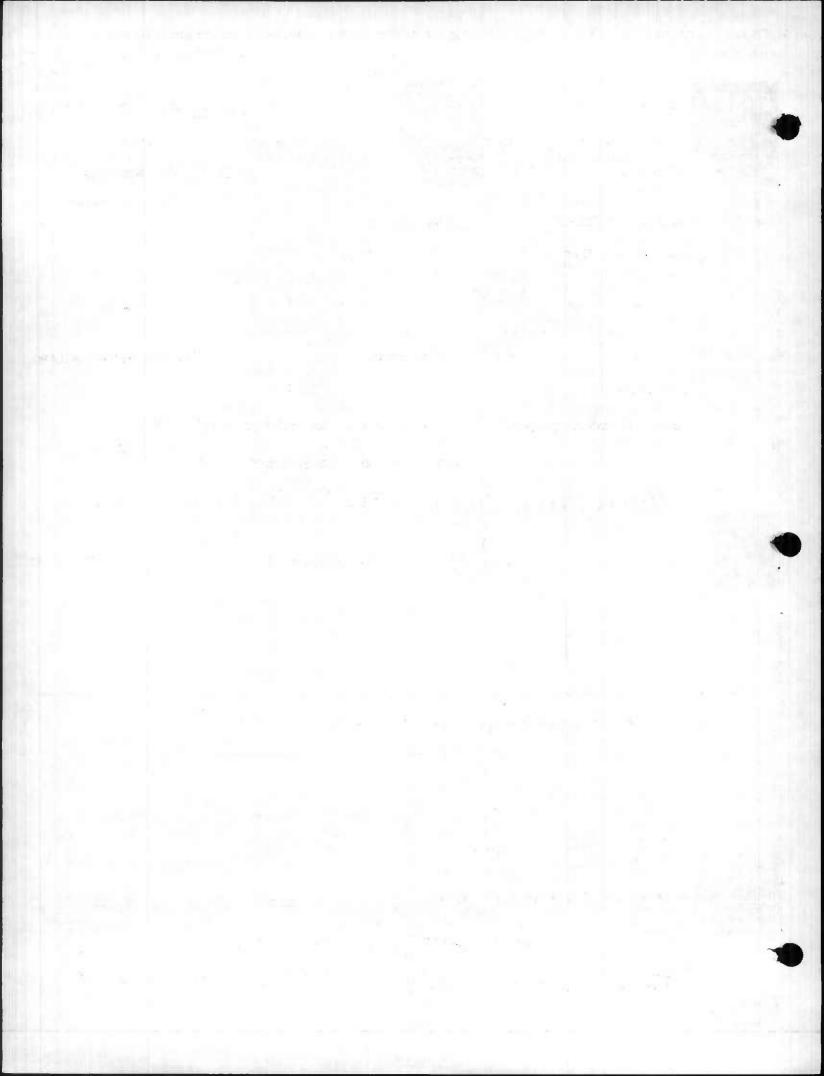
30. Nema and eddress of person who complated cause of deeth (Itam 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

hysici	an	1. Decedent's Neme (First, M								2. Dete of Deet Month	h Dey	Mana	Time of Death
/Medic			łash							(2.5	28	U 5:40 ar
xamir	er	4a. Fecility Name (If not institu			•					ation of Death	4c. County		
	-	Greater Balti 5. Sociel Security Number	more M			er last birthday)	If Under 1 Ye		WSON er 24 Hrs.	R Date of Birth	Bai	timore	(State or Fornin
neral ector	d	225–48–1466 Usuel Residence of Deceden	1□ M	2√ F 10		Yrs.	Months De		Min.	8. Date of Birth (Mopth, Day, OFIL 14,	1895	Virginia	(State or Foreign
del	Į.	10e. Stete 10b. Cou	nty			ity, Town or Lo							nside City Limits
notified at	cto	Maryland Balt:	more		Balt	imore Co	-						Yes 2 No
ust be notifie	Funeral Directo	9016 Perryvale Ro	oad				10f. Zip Cod 21236	e			og. Citizen of N JSA	Whet Country?	
Evaluación III	by	11. Marital Stetus 1 □ Never Married 2 □ N X Widowed 4 □ Divor	Married	Wes Deceden Armed Forces 1 Yes 2 This Yes, Give Yeer or Detes	No		Vas Decedent Yes, specify C □ Yes 2 ☑			ify Yes or No- ican, etc.)		ea - American Ir ck, White, etc.	ndien,
	Completed	15. Dece (Specify only his Elementary/Secondery (0-1	T	ion ompleted) College (1-4or N/A	5+)	16a. Deced (Give life. L	ent's Usuel Ockind of work do NOT use re	cupation ne during m tired)	ost of workin	9		usiness/Industr	
event, me	Be C	17. Fether's Name (First, Mide	tle, Last)	IV/A		IIIOOSERCE	ДСТ	18. Mo	ther's Neme	(First, Middle, M			-pipmyea
tic ev	To B	Jack Halsey						Ada	Delp				
aumatic e		19e. Informent's Name/Relet	onship (Type,	Print)		19b. Meilin	g Address (Str	eet end Nun	ber or Rural	Route Number	City or Town,	State, Zip Cod	le)
her tr		Lucille Schoelko	pf (Daug	ghter)					Baltimor	e, Maryla			
any injury or other traumatic once.		20e, Method of Disposition 1 Burial 2 Cremeti 4 Donetion 5 Othe		ovel from State	3	Plece of Dispo cametery, cren	-		January	Dete 28,1998	Mouth of Virg	City or Town, E Wilson,	Stete
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d for use es the bunel-transit	n/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest	e b c d	CON	Due to (or es e consequence es	uenca of):	d ise	250				10 years
2	sicia	Pert II. Other significant cond	litions contrib	uting to death	but not re	sulting in the ur	deriving cause	aiven In Pe	rt I.	23b. Did to	bacco use co	ntribute to the	cause of death
	y Phys					lent		•		1 🗷 Y			/ 4□Unknow
nen en pinore y	Completed by Physician/N		0	'						24e. Was e perform		eveileb	utopsy findings le prior to tion of cause h?
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director,	Be	25. Wes case referred to med exeminer?							ce of Deeth	(Check only on	e)		
al dire	2	1 ☐ Yes 2 ☑ No	Hosp	1 🖾 Inpat		ER/Outpetien	3 DON			e 5 🗆 Reside			
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ed in by	Certifi		ald not be ermined	28e. Piece of Ir building, e	njury - At t	nome, ferm, stre ify)	eet, fectory, offi	ca	21	3f. Location (St City or Town		per or Rurel Ro	ute Num <i>ber</i> ,
ietely fill	dical	29a. Certifier 1 Certi (Check only 2 Medione)	ying Physicia al Examiner:	en: To the best On the basis of end menner s	of examin	owiedge, deeth etion end/or inv	occurred et the estigetion, in m	e time, date ly opinion, d	end plece, er eeth occurre	nd due to the co	euse(s) end ma ate end plece,	anner es steted end due to the	l. ceuse(s)
сош	M	29b. Signature end title of car	ifier				29c. Lic	ense numbe	r	2	9d. Dete signe	d (Month, Day,	Year)
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Elnora

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** ELNORA C.. 5:55 pm January /Medical 4a. Facility Nama (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STELLA MARIS HOSPICE (MERCY) BALTIMORE N/A 7. Aga (In yrs. last birthday) If Under 1 Yeer If Undar 24 Hrs. 5. Social Sacurity Number 6. Sex 8. Data of Birth Month, Pay, Year) 2/6/14 9. Birthplaca (State or Foreign Country) **Funeral** 1□M 2FF Months Days Hours 83 Yrs. 245 28 7873 N.C. Director Usual Rasidance of Decedant the Maryland 10a. Stata 10c. City, Town or Location 10b. County 10d. Insida City Llmits 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Exerciser must be notified at 1 ∰ Yas 2 □ No N/A Director BALTIMORE 10e. Straat and Numbar 10f. Zip Code 10g. Citizan of What Country? 2467 WESTPORT ST. 21230 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ∰ No If Yas, Giva 'Yaer or Detas: Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite, any injury or other traumatic event, the Medical Examina 1 Navar Married 2 Married Maryland 21215-0020 1 Yas 2 No Specify: SpecifiAFRO AMERICAN by 3# Widowad 4 □ Divorcad Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **PROCESSOR** DOVER POULTRY 12 0 18. Mothar's Nama (First, Middle, Maidan Surname) 17. Fathar's Nama (First, Middla, Last) THOMPSON **FEASTER** CASSIE PERKINS 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Typa, Print) 2467 Westport ST. BALTIMORE, MD. RAYMELL GLADDEN DAUGHTER 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State # Burial 2 ☐ Cramation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Spacify) ARBUTUS MEM. PARK 1/31/98 ARBUTUS, MD. 21. Signature of Funaral Sarvice Licensea 22. Name and Addrass of Facility
ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. Part 1. — ar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errast, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsat end Death **Physician** /Medical Immediate Causa (Final LUNG CANCER UNKNOWN disaasa or conditi-rasulting in daath) Examiner Dua to (or as a consequence of): Examiner ician and buriel-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated avants resulting in death) Last Dua to (or as a consequence of): physician s the buriel Box 68760 Physician/Medical Dua to (or as a consequence of): attending Po P.O. Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by t d be detect 1 PYes 2 No 3 Probably 4 Unknown Records, p 24b. Wara autopsy findings aveilable prior to complation of cause of death? been si 24a. Was en eutopsy performed? Completed 1□ Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was casa rafarrad to medical examiner? 26. Placa of Death (Check only one) Stella Maris at Mercy Be Other: 4 Nursing Homa 5 Residence 6 NOther (Specify)Hopice Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetlent 3 ☐ DOA 1 Yas 2 No 2 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how Injury occurred 27. Mannar of Deeth 28b. Time of 28c. Injury et Work? Certification: Attending 5 Panding 1 Netural 2 Accident death. 1 TYas 2 No invastigation or Attend after death Director: 6 Could not be datermined 3 Suicida 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 ☐ Homicida 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, dete and place, and dua to tha causa(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29e. Certifiar (Check only one) Medical No.24 29b. Signeture end titla of certifiar 29c. Licansa numbar 29d. Date signed (Month, Dey, Yaar)

State Registrar FERRO MO 32. Registrar's Signatura 040480

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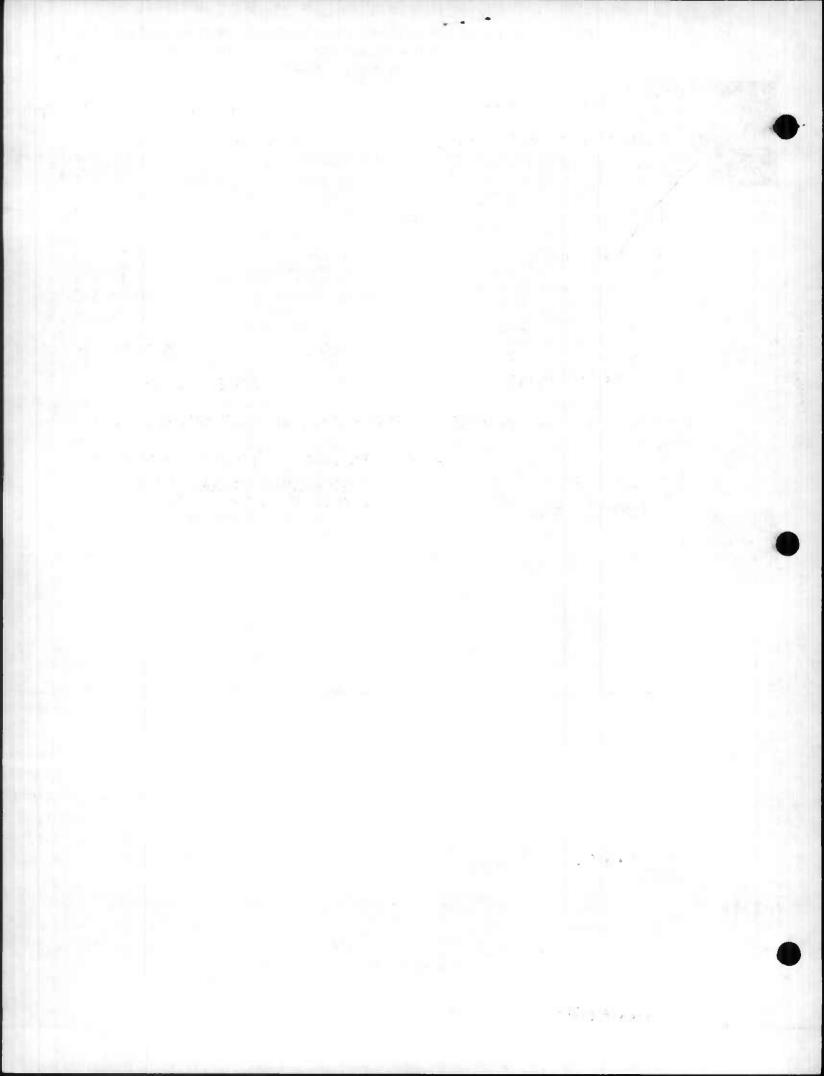
DI. Derrous

FERNANDO

3 0 1998

31. Deta filed (Month, Day, Yaar)

30. Nama and eddrass of person who completed causa of death (Itam 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 3. Time of Death 2. Date of Deeth **Physician** /Medical HOSPITAL 7. Age (In yrs. last birthday) 4b. City, Town or Location of Death 4c. County of Daath Examiner 000 Samaritan 5. Social Security Number 2/3-07-5278 Social Security Number 6. Sax If Under 1 if Undar 24 Hrs. 8. Dete of Birth Birthplece (Stata or Foreign Opuntor) Funerai 1 M 201 Months Days Hours Min Director 1908 Usuel Residence of Dacedent the Maryland 10a. Steta 10b. County 10c. City, Town or Location 10d. insida City Limits Baltimore r than "natural", or items 23a or 28a-f st the Medical Examinar must be notified 1 Yas 2 No Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? death with 150211 21213 12. Was Dacedent Ever in U.S. Armed Forces? 1 Yes 2 DAG Raca - American Indien, Bleck, White, etc. 11. Marital Status Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 200 No 21215-0020 Black If Yas, Give Year or Dates: Specify Be Completed by 3 Widowed 4 □ Divorcad 15. Decadent's Education (Spacify only highast grada complated) 18e. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry ulth and Mentei Hygiene. 27 is marked other than r traumetic event, the Me Elementary/Secondery (0-12) College (1-4or 5+) Beautican 12 Baltimore, Maryland 17. Father's Neme (First, Middle, Last) ent of Health and Mentel H. It item 27 is marked oth 18. Mother's Name (First, Middle, Maidan Sumama) Pages 1 and 2 should be 2 William Mallie Grayson evonshire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Rout Number, City or Town, State, Zip Code) Broadway Baltimore, Md. 21213 George Moore 20e. Method of Disposition 20b. Place of Disposition (Nama of cametery, oramatory or other place 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Co. Md. re of Funeral Se Battimore Hatt. Enter le diseesa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest hock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated avents resulting in daath) Lest 68760 Dua to (or as a consaquance of) P.O. Box Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1□ Yes 2DANo 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings available prior to 24a. Was en eutopsy performed? completion of cause of deeth? The law 1 Yes 1 Yas 2 No Division of Vital 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ inpatiant 2 ☐ FR/Outpatient 3 ☐ DOA 1 Yes 2 No 10 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Attor Attending 5 Pending Investigation Matural 1 Yes 2 🗆 No 2 Accident after death 3 Suicide 6 Could not be determined 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Spacify) in by 4 ☐ Homicide 8 To the Hospital within 24 hours a To the Funeral D 29a, Certifier Certifying Physicien: To the best of my knowledge, death occurred et the time, date end pleca, end due to the cause(s) and manner as steted. | Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. Medical

29c. License number

ZENWOOD AVE

29d. Date signed (Month, Day, Year)

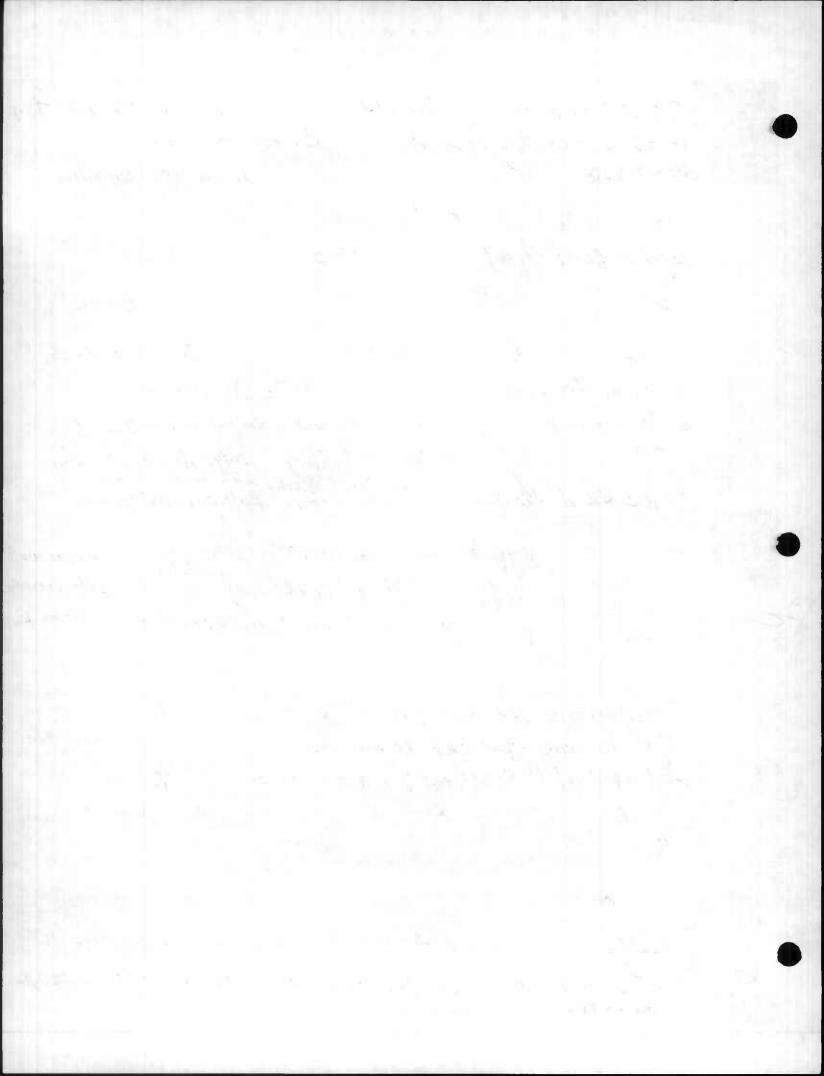
State Registrar

29b. Signature end title of certifier

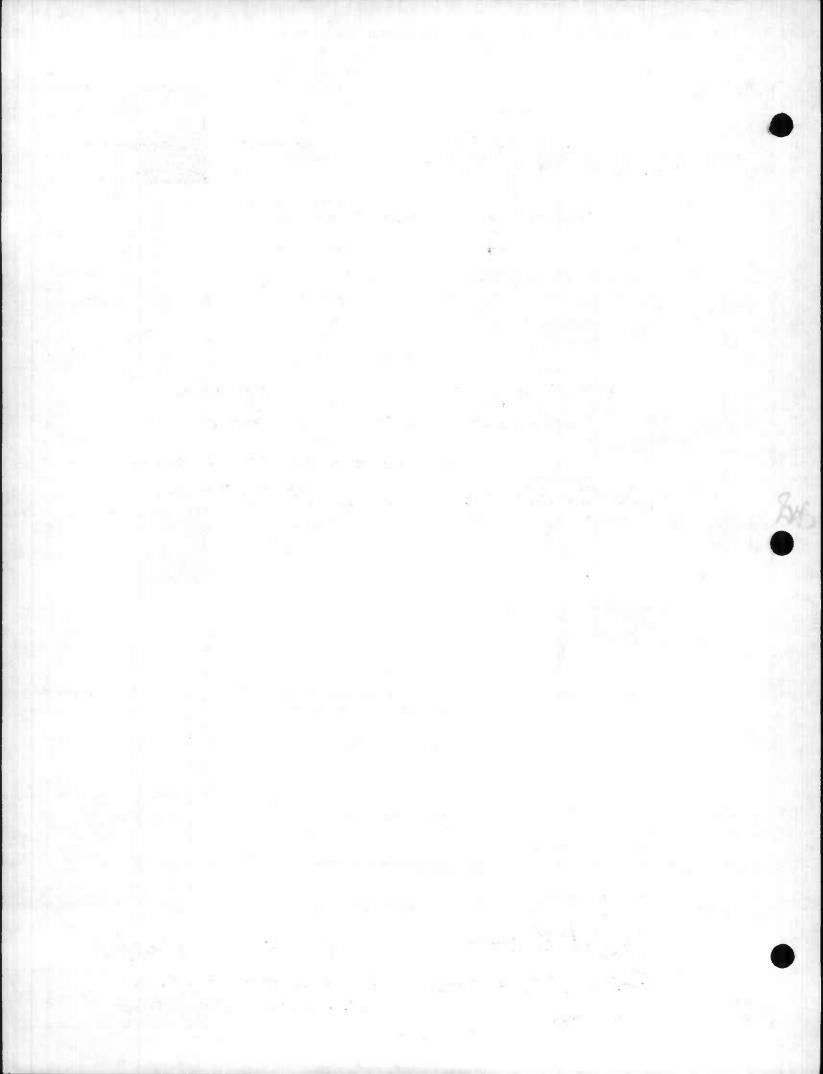
of person who completed cause of death (Item 23a) (Type, Print)

H. MID

MD HHTN.
Registrer's Signature
Window Rendell



	1	. Decedent's Neme (First, Middle, L	.ast)		007	imouto o	f Death	2. Dete of De	Reg. No.	3. T	ime of Deeth
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eral					e L iest birthday)	If Undar 1 Yas		LIS s. 8. Date of Bird (Month, Da	Anne	9 Birthpiece (S	
tor	-	478-30-5892	1 X M 2□ F	99	Yrs.	Months Dey	s Hours Min			9. Birthpiece (S Country) Misso	uri
		0a. Stete 10b. County		10c. Ci	ty, Town or Loc	cation				10d. Ins	ide City Limits
rector		MD Anne	Arundel	,	Severn	a Park				10	Yas 2 No
Funeral Director	1	0e. Street and Number 487 St. Brides	s Court			10f. Zip Code 21146			10g. Citizan of V		
by		1. Maritel Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Deceda Armed Forca 1 XYes 2 If Yes, Give Yaar or Dete	S? No Tattat	if	Vas Decedant of Yas, specify Cu ☐ Yes 2 No	f Hispenic Origin? (uban, Maxican, Pua o <i>Specify:</i>	Specify Yas or No rto Rican, atc.)	- 14. Rac Bied Specify	e - American indick, White, etc.	ien,
peted	_	15. Decedent's (Specify only highest g	Education rada complated) College (1-4d	or 5+)			upation e during most of wo red)	orking	Publ Schoo	-	
္မ	-	7. Fether's Nema (First, Middle, Las	5+		Teach	er/Pri	ncipal				tem
To Be Comp		Edward Vi	,	200				ome (First, Middle,		10)	
To		9e. Informent's Neme/Reletionship		nes	19h Melling	n Address /Stre	et and Number or F	nna Rul		State 7in Code	
	- 1	Louise M. Fluets		er		t. Brid		Severna F			
2	-	0a. Method of Disposition	0	20b. I	Place of Dispos	ition (Neme of		Dete		City or Town, Str	ate
		1 ☐ Burial 2 ☐ Crametion 3 4 ☐ Donetion 5 ☐ Other (Spec	☐Removei from Ste	(0)		atory or other p		/20/00	D-1-4-	100	
once.	1	1. Signeture of Funerei Service Lic		110		Name and Add	, Inc. 01 ress of Facility	120/90	Baltimo	ore, MD	
Suc		Dawn F McDor 23a. Part1. Enter tha disease, or co- shock, or heert feilure. List only	Nichma	IN	Cr	cemation	Society	of Mary	land, Ir	nc.	
n/Medical Examiner	31	mmediate Cause (Finel lisease or condition asulting in deeth) sequentially list conditions, eny, leeding to immediate ause. Enter Underlying Lause (Disease or injury net initiated evants esulting in deeth) Last	b. Pecs	Due to (d	or as a consequence of the conse	uence of):	TAIL			27	TOPES
/ Physician/	P	art II. Other significant conditions	contributing to death	but not ras	uiting in the un	deriving cause (nivan in Part I	23h Did	Inhacon use co	ntribute to the c	ture of death?
d by Physician/N	-		outributing to doub			oonying caddo (givani in Falti.		Yes 2□ No	3 Probably	4 Unknown
Completed	-							24a. Wes perio	en eutopsy med?	24b. Were auto evalleble completion of death?	prior to
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Cat		3 Suicida 6 Could not determine	A 259. PIGCS OF	Injury - At h etc. (Specil	ome, ferm, stre fy)	et, fectory, office	9	28f. Location (S City or Tox	Street and Numb vn, Steta)	er or Rural Route	Number,
Certification:				st of my kno	wledge, death	occurred et the	time, dete end plec	e, and due to the urred et the time,	cause(s) end me	enner es steled. and due to the ca	iuse(s)
edical Certificat	2	9e. Certifier (Check only one) 1 Certifying P	thysician: To the be- iminer: On the basis and manner	of examine	ition and/or inva	astigetion, in my	opinion doon oo		4		
Medical Certification: To Be		(Check only 2 Medical Exa	miner: On the basis	of examine	ation and/or inva		nse number			d (Manth, Day, Yo	ear)
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Medical Certificat	2	(Check only 2 Medical Exa	Iminer: On the basis and manner	of examine steted.		29c. Licer			29d. Date signed	198	ear)



98-0268-510 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene DAVID JONES Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY 18, 1998 DAVID JONES JR. 03:20 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner 915 WEST BALTIMORE STREET BALTIMORE N/A Data of Birth (Month, Day, Year) 6/26/78 5 Social Security Number Birthplace (Stata or Foraign Country)
 MD 7. Aga (In yrs. last birthday) **Funeral** #DM 2□ F Months Days Hours 19 218 98 1155 Yrs. MD. Director Usual Residence of Decedent with the Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exercises must be notified at 1# Yes 2□ No Director BALTIMORE MD. N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 ST). 6 STRICKER USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexicen, Puarto Ricen, etc.) 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2# No If Yes, Give Race - Americen Indian, Black, Whita, etc. 11 Marital Status filed within 72 hours after 1# Never Married 2 Married SpecifAFRO AMERICAN 1 Yes 2 No altimore, Maryland 21215-0020 Specify: by 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 18. Mother's Name (First, Middla, Maidan Sumama) 17. Father's Neme (First, Middle, Last) . Pages 1 and 2 should be fill ment of Haalth and Mental Hant: If Item 27 is marked oth jury or other traumatic even Be DAVID JONES SR. CHARLENE BOWIE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) CHARLENE BOWIE MOTHER 6 N. STRICKER ST. BALTO. MD. 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 1/24/98 LANSDOWNE, MD. MT. ZION 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ESTEP BROTHERS 1300 EUTAW PL. FUNERAL HOME P BALTO. MD. 212 Ce nter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician /Medical Immadiata Causa (Final disease or condition resulting in death) Examiner Examine burlal-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 edical Dua to (or as a consequance of): ğ 2 Physician/M 997 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 Probably 4 Unknown yd bengis 1 ☐ Yes 2 ☐ No 3 2 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of ceuse of death? page 2 Yes 2□No certificate 1 Yes 2 No 89 25. Was cese referred to medicel examinar? 26. Place of Death (Check only ona) Hospital: To 11 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 1 Natural 5 Pending 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after death. Director: An 1 ☐ Yes invastigation 2 Accident a Location (Streat and Nu City or Town, State) 6 Could not be 3 ☐ Sulcide 4 Homicide 6

State Registrar 31. Date filed (Month, Jay War)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

0 1998

111 Penn Street, Baltimore, Maryland 21201 32 Registrar's Signatura Giria Davidson

ompleted cause of death (Item 23a) (Type, Print)

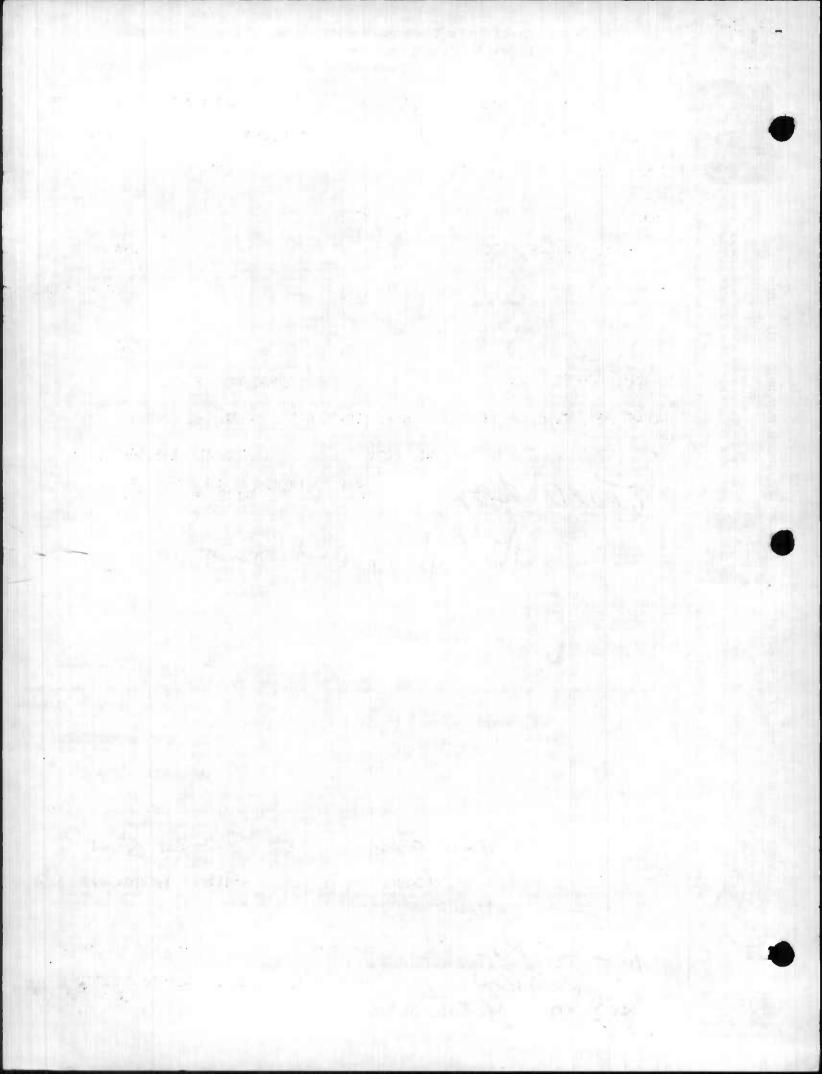
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29c. License number

OCME

29d. Date signed (Month, Day, Year) JANUARY 18, 1998

DHMH 16 Rev 6/95



Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth Month **Physician JEANNETTE** KLEIN JUTEN JAN 1998 23 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SANDY SPRING MONTGOMERY FRIENDS NURSING HOME If Undar 1 Yaar If Undar 24 Hrs. Months Days Hours Min. 8. Data of Birth Month, Day, 1909 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign WISCUNSIN **Funeral** Days 1 M 2 F Months 141 24 2761 88 Yrs Director Usual Rasidanca of Dacedant 10a. Stata 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MONTGOMERY BETHESDA MD. Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20816 UNITED STATES STREET 4008 61 st Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Raca - Amarlcan Indian. permit. Peges 1 end 2 should be filled within 72 hours effer to Department of Health end Mentel Hygiene. Important: If Nem 27 is marked other than "natural," or Item any Injury or other traumatic svent, the Medical Control of Mode. 1 Nevar Married 2 Married 1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 No þ 3 ☐ Widowed 4 ☐ Divorcad Year or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SCHOOL TEACHER **EDUCATION** 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) EDWARD F. KLEIN IDA GRUBB 2 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) BETHESDA, MD. 20816 MILFORD A. JUTEN, HUSBAND 4008 STREET, 61ST 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) METROPOLITAN CREMATORY 1/24/98 ALEXANDRIA, VIRGINIA 21. Signature of Funaral Sarvice Licanson 22. Nama and Addrass of Facility MURIEL H. BARBÉR FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** Immediata Causa (Final disaesa or condition resulting in death) /Medical & HYPERTROPHIC 131201017019111 Examiner Physician/Medical Examiner STHEOPAL The lew requires that the death certificate be executed physician and s the buriel-transit Division of Vital Records, P.O. Box 68760,

Sequantially list conditions, if any, leading to immadiata causa. Enter Undarlying Cause (Disaase or injury that initiated events rasulting in daath) Last

ENSIDE MAPERT Dua to (or as a consequanca of) JENERE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

3. Tima ot Death

10d. Insida City Limits

Approximata Intarval Batween Onset and Death

CARS

WHITE

1 ☐ Yas 2 ☑ No

AM

24a. Was an autopsy performed? 24b. Ware autopsy tindings available prior to completion of causa of death?

1 Tyas 2 No

25. Was case reterred to medical axaminar? Hospital: 1 Yas 25 No

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

26. Placa of Deeth (Check only ona) Othar: Nursing Homa 5 Rasidanca 6 Othar (Specify)

1 ☐ Yas 2 ☑ No

27. Menner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 5 Panding invastigation Netural 2 Accident 6 Could not be datarmined 3 Sulcida 4 Homicida

28c. Injury at Work? 28d. Dascribe how injury occurred 1 ☐ Yas 2 ☐ No

28e. Pleca of Injury - At homa, tarm, straat, tactory, offica building, atc. (Spacify) 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a, Cartifian

La Davidson

Cartifying Phyatotan: To the best of my knowledge, death occurred at the time, date and piace, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and titla of cartifian 29c. Licansa number 29d. Data signed (Month, Day, Year)

30. Nama and addless of parson who complated cause of deeth (Itam 33a) (Type, Print)

SILVER SPRING Md PURTURY CLOVERLY 733 57 JOHH 31. Data filad (Month, Day, Year) JAN 3 0 1998 32. Registrar's Signatura

State Registrar

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signed by t

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After

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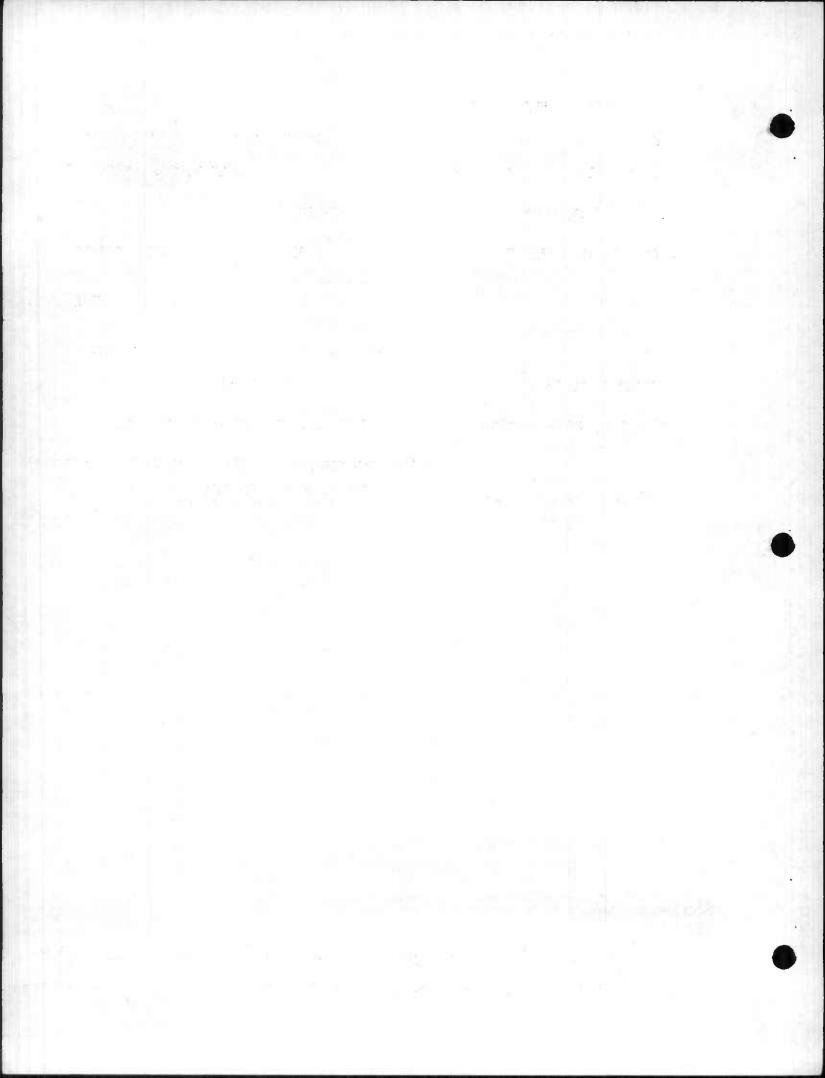
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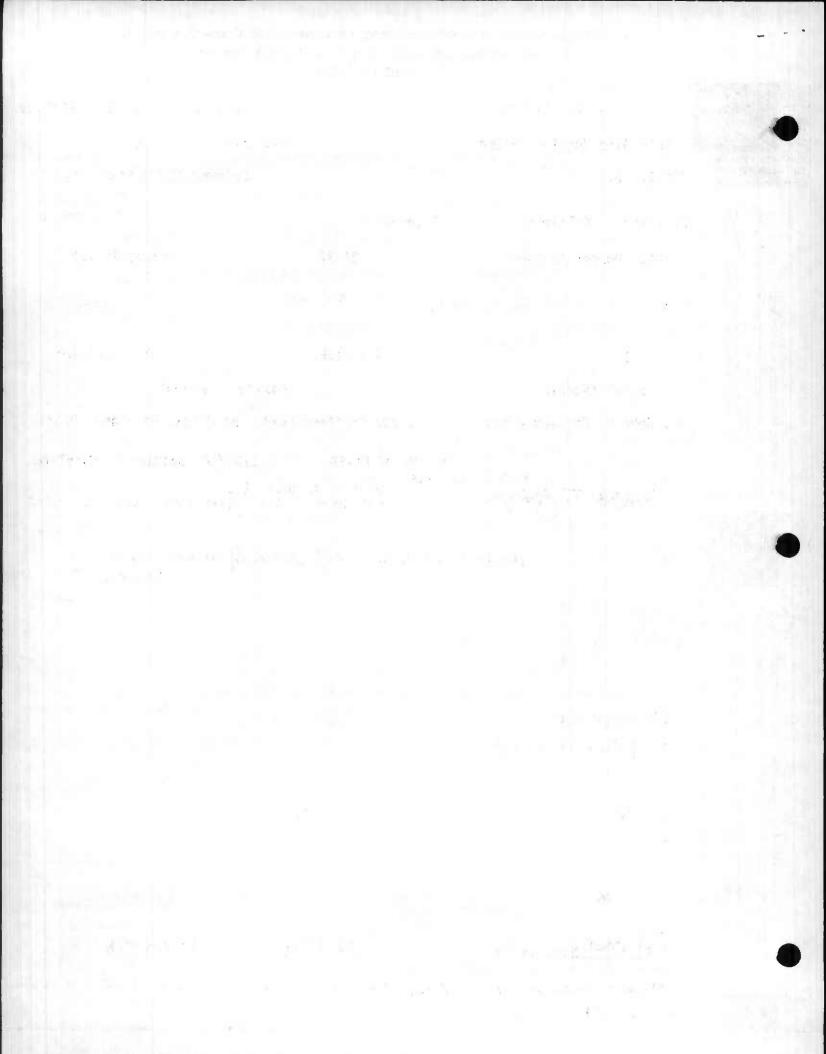
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State of Maryland / Department of Health and Mental Hygiene

County Number D-6099 ance of Decadant 10b. County and Balt and Number 16 Dorset A Status ar Married 2 Marrie Specify only highest cy/Secondary (0-12) 12 Name (First, Middla, L amuel Katch ant's Name/Ralationshi ohn W. Katch of Disposition ial 2 Cremetion 5 of Other (Specify of Funeral Sarvica Li median 5 Tentar tha disaasa. or cell of Funeral Sarvica Li median 5 Tentar tha disaasa. or cell of Funeral Sarvica Li median 5 Tentar tha disaasa. or cell of Funeral Sarvica Li median 5 Tentar tha disaasa. or cell of Funeral Sarvica Li median 5 Tentar tha disaasa. or cell of Funeral Sarvica Li median 5 Tentar tha disaasa. or cell of Funeral Sarvica Li median 5 Tentar tha disaasa. or cell of Funeral Sarvica Li median 5 Tentar tha disaasa. or cell of Funeral Sarvica Li median 5 Tentar tha disaasa. or cell of Funeral Sarvica Li median 5 Tentar tha disaasa. or cell of Funeral Sarvica Li median 5 Tentar tha disaasa.	Katchan giva streat and number) Sing Center 6. Sax 1 M 2 F T. Age (In 12 M 2 F) Simore 10 M 2 F 10 M 2 F 10 M 2 F 10 M 2 F 10 M 2 F 10 M 2 F 10 M 2 F 10 M 2 F 10 M 2 F 10 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M	19b. Ma 11 20b. Placa of Discometery, or Gardens avoyna e death. Do not e	Months Days Location ale 10f. Zip Coda 2123 3. Was Decedant of If Yes, specify Cult 1 Yes 2 No. 2 No	Hours Min. Hispanic Origin? (Spen, Mexican, Puerto Specify: Inpation e during most of worked) Is Mothar's Nam Maxi Haxi Fers Road Acception of Facility J. Ruck, rford Road Adapting, such es cardiac	s. Data of Birti (Month, Da) September Dacify Yes or No- Rican, etc.) And (First, Middla, ne (Unkt ral Routa Numbe Bradsl Data 1/31/98 Inc. I Balti or raspiratory er	Ac. County Ac. County No. Year) 10g. Citizan of V Unite 14. Racci Bleck Specify 16b. Kind of Bu Steel Maidan Sumam nown) In, City or Town, Naw, May 20c. Location Baltim more, M. rast,	9. Birthplace (State or Foral Country) West Virginia 10d. Inside City Limit 1 Yes 200 M What Country? ed States e - American Indian, ck, White, atc. White usiness/industry Production Ta) Stata, Zip Code) ryland 21021 City or Town, Stata Hore, Maryland aryland 2121 Approximate Interval Between Death Onset end Peath	and its
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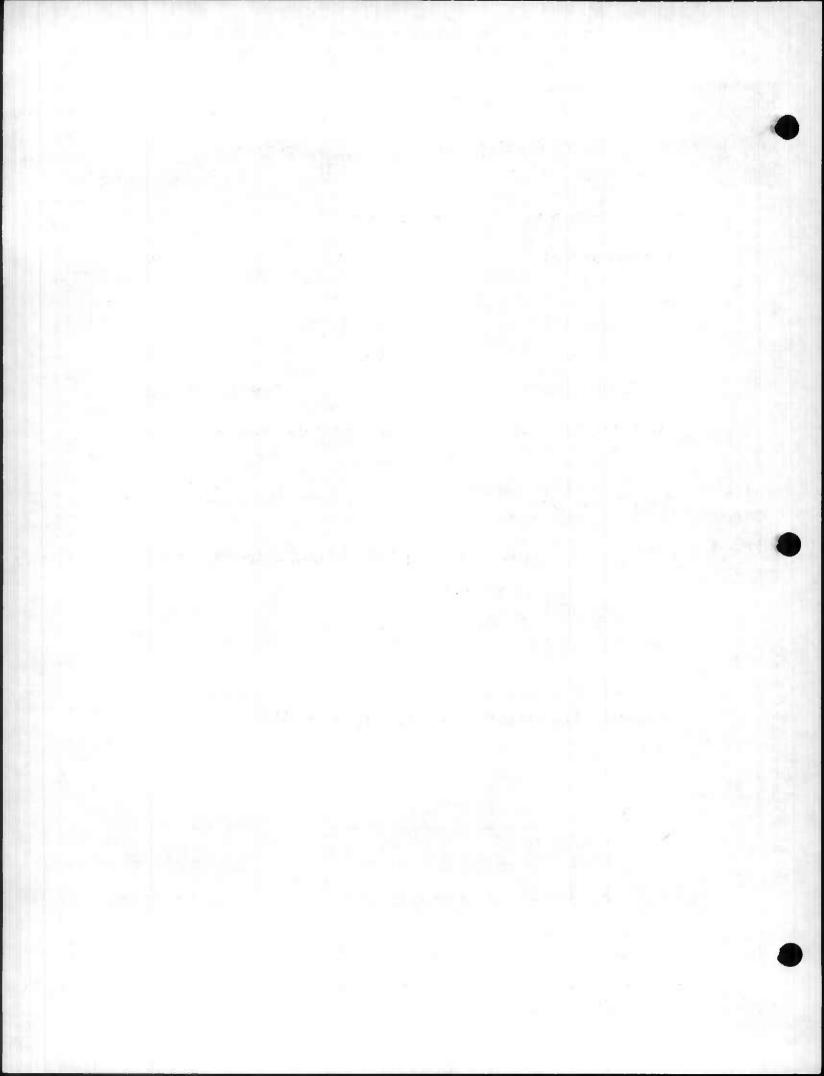
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Lest) 2. Data of Death 3. Time of Deeth **Physician** Month Doris Hurtt Kiser JAN 28, 1998 11:35am /Medical 4e. Fecility Neme (If not institution, give street end number) 4b City Town or Location of Deeth 4c. County of Deeth Examiner Robosson Court Nursing Cer Randallstown
If Under 24 Ars. 8. Dete of Birth
Hours Min. (Month, Day, Year) Center Baltimore If Under 1 Yaar Birthplece (State or Foraign Country) **Funeral** 1□ M 2□ F Yrs Director 213-03-9888 MAR 9, 1916 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at MD Baltimore Director 1 ☐ Yes 2 ☐ No Randallstown 10e. Street end Numbar 10f. Zip Code 10g. Citizen of What Country? 6 "natural", or items 23a 4511 Robosson Road permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a and Injury or other traumatic event, the Medical Examinat mans once. 21133 12. Wes Decedant Evar in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - Amaricen Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2√☐ No by Specify: White 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Attendent School Bus 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sur, Be Thomas D. Hurtt Tamsey A. Slaughter 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Judy Daniels/daughter 20b. Plece of Disposition (Name of camatery, cremetory or other plece)

304 Knotts Circle Woodstock, GA 30188
20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 01/29/98 Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Fineral Sarvice-Licensee Communication Society of Maryla 299 Frederick Rd. Baltimore 23a. Pert1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cerdiec or raspiratory arrast, shock, or heer feilure. List only one cause on each line. 2 Name and Address of Facility of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 **Physician** Immediete Ceuse (Final disease or condition resulting in death) /Medical PROBABLE MYOCARDIAL INFARCTION < 5Min Examiner Due to (or es e consequence of) SEPSIS Physician/Medical Examiner physician and the burial-transit To the Mospital or Attanding Physician: The law requires that the death certificate be associated within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettanding physician and completely filled in by the funcet director, page 2 should be detached for use as the buntal-transit Sequantially list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last ERITONITIS Box 68760, P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown RECENT LOLECTOMY, CONGESTIVE HEALT Records, Completed by 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? FAILISAE Division of Vital 25. Wes case referred to medical exeminer?

1 Yas 2 No Be 26. Piece of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Death 28e. Dete of Injury (Month, Dev Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 D Homicide 1 Certifying Physicien: To the best of my knowledge, daath occurred at the time, date end plece, end due to the ceusa(s) and manner as steted.
2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the ceuse(s) and manner stated. 29a. Certifier 29b. Signature and title of certifian 29c. License number 40390 LD COURT RO, #305, PANDALLICOUN, MDZ113) State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 1:26 Hm Eva Margueritha Kfoury January 24, 1998 /Medical 4a. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 2061 Durham Road Fallston Harford If Under 1 Year If Under 24 Hrs. | Months Deys Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys Months 1 □ M 2 🕱 F Yrs. Director 266-25-8555 48 Feb 6, 1949 Sweden Usual Residence of Decedent with the Marylend 10e. Stete 10b. County 10c. City, Town or Location if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Harford **Fallston** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours effer death v. Depertment of Heelth and Manial Hygiene. important: if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, tra Medical Experience 2008. 2061 Durham Road 21047 USA Funeral 13. Was Decedent of Hispenic Origin? (Specify Yas or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Raca - Amarican Indian, Black, White, etc. 11. Meritel Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Cottaga (1-4or 5+) 12 5+ Nurse Psychiatric Hospital 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be John **Kallstrom** 2 Anna-Lisa Thundberg 19a. informent's Neme/Reletionship (Type, Print) 19b. Melling Addrass (Street end Number or Rurel Route Numbar, City or Town, State, Zip Code) Salah Kfoury/Husband 2061 Durham Road, Fallston, MD 21047 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 XCremetion 3 ☐ Removel from State 5 ☐ Other (Specify) 4 Donaties Baltimore-Washington Crematory 1/30/98 Laurel, Maryland Service Licensed 22. Name end Address of Fecility Lemmon Funeral Home Bryan W. Clary 10 W. Padonia Road, Timonium, MD ease, or complications that causere. List only one cause on each d the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, Approximete Intervel Between Onset end Daeth **Physician** Immediate Ceuse (Finel disease or condition rasulting In deeth) METASTATIC OVANIAN CANCER /Medical Examiner Due to (or es a consequence of). Physician/Medical Examiner physiclen and the burial-transit The law requires thet the death certificete be executed Sequentielly list conditions, if eny, leeding to immediate causa. Enter Undarlying Cause (Disease or injury that initieted evants Due to (or es e consequença of): thet initieted evants rasulting in deeth) Lest Due to (or es a consequence of): 98 ettending p signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara eutopsy findings eveilable prior to completion of cause of deeth? been si 24e. Wes en eutopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Attanding Physician: Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 25 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: 1 Naturel 5 Pending investigation death. 1 Yes 2 No 2 Accident i or Attand efter death Diractor: / 3 Sulcide 6 Could not be 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours efter To the Funeral Director Completely filled in 29a. Certifier Certifying Physician: To the bast of my knowledge, death occurred at tha time, data and piece, and due to the ceuse(s) and menner as stated. Medical 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.

Box 68760.

P.O.

Division of Vital Records,

30. Neme and addrass of person who completed causa of daeth (Item 23e) (Type, Print) Joan Edwards, MD 31. Dete filed (Month, Day, Year)

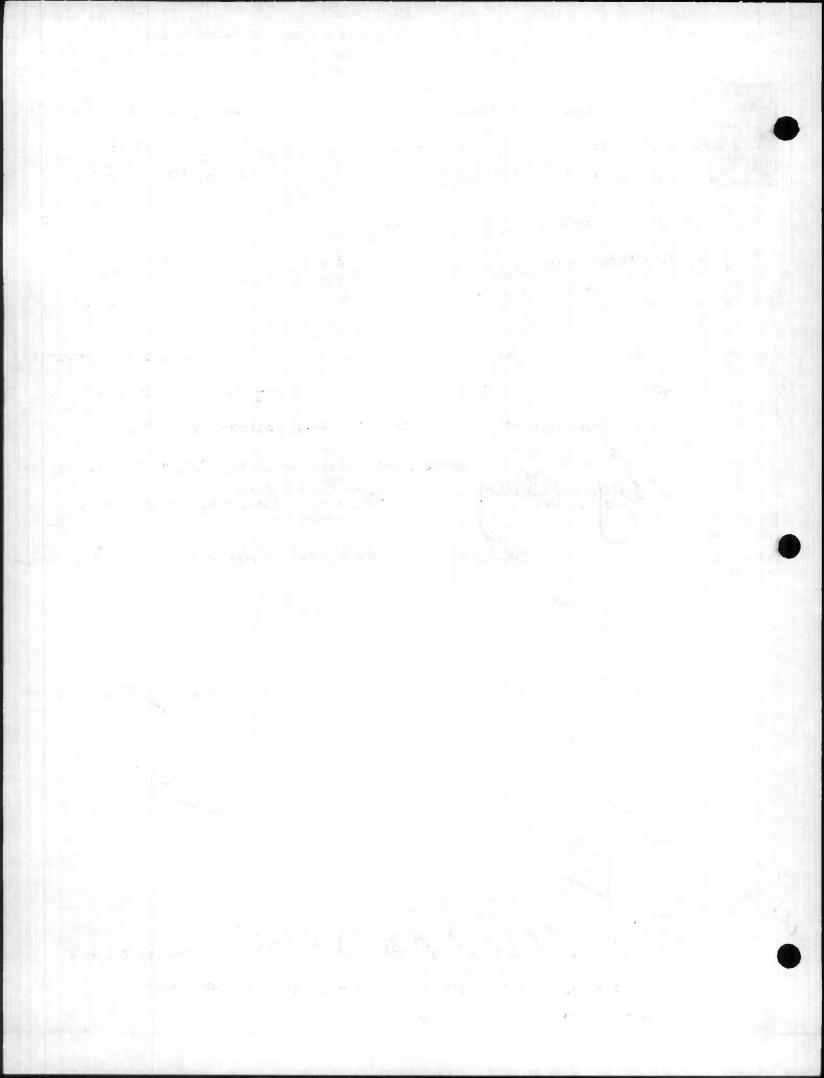
\$9b. Signature and title of certifier

2112 Belair Road, suite 4A, Fallston, MD 21047 Registrar's Signeture whip Davidson Bandall

29c. License number

29d. Date signed (Month, Dey, Year) January 27, 1998

State JAN 3 0 1998 Registrar

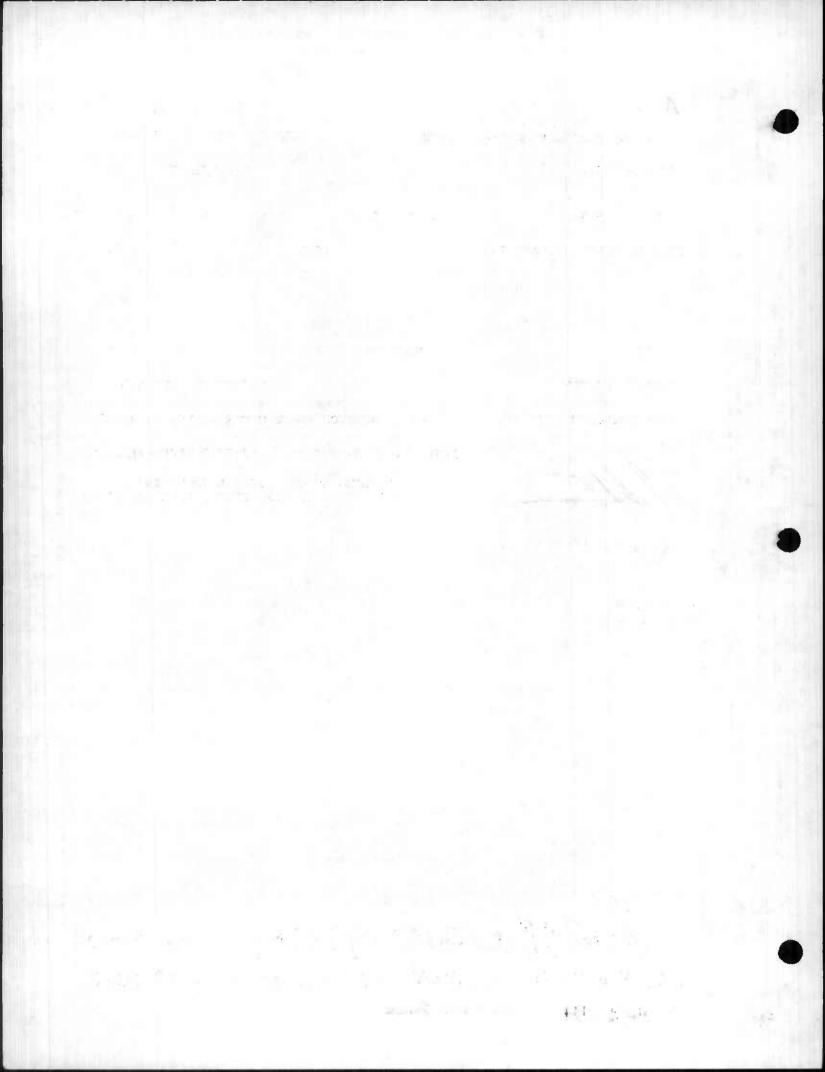


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Name (First, Middle, Last)	of Death Reg. No. 98 02432
ician dical niner	Alfred Kershaw 4a. Facility Name (If not institution, give street and number)	Month Day Yeer January J 1978 11: 25 4b. City, Town, or Location of Deeth ELLICOTT CITY HOWARD
al or	215-01-8295 15 m 257 90 Yrs.	
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. inside City L
Ď	MD HOWARD ELLICOTT CITY	1 XYes 2
Funeral Director	10e. Street and Number 10f. Zip Co. 3004 N. RIDGE RD. APT 704	de 10g. Citizen of What Country? 21043 U.S.A.
by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Amould Forces? 1 Yes, Sie Year or Dates: 13. Was Decedent Ever in U,S. Amould Fig. Sie No If Yes, Gie Year or Dates:	t of Hispenic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. Specify: WHITE
Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 10 16e. Decadent's Usuel O. (Give kind of work de life. DO NOT use re	ccupation (one during most of working etired) 16b. Kind of Business/Industry A & P
Be	17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
2	STANLEY KERSHAW	GENEVIEVE EFFERSON
		treet and Number or Rural Route Number, City or Town, State, Zip Code) CON PLACE CATONSVILLE, MD 21228
	20a. Method of Disposition 1\(\text{Durial 2 \subseteq Cremation 3 \subseteq Removel from State} \) 4 \subseteq Donation 5 \subseteq Other (Specify) 20b. Place of Disposition (Name of Commetery, cremetory or other DRUID RIDGE CEM	of place) Dete 20c. Location - City or Town, State
		ddress of Facility ASHTON FUNERAL HOME, INC. ONDSON AVE. CATONSVILLE, MD 21228
n/Medical Examiner	Sequentially list conditions at any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included events resulting in death) Last e. Due to (or as a consequenca of): Due to (or as a consequenca of): Due to (or as e consequence of): d.	E REGURGITATION I YEA
y Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause SICK SINUS SYNDRUME	e given in Part I. 23b. Dld tobacco use contribute to the cause of de 1 Yes 2 No 3 Probably 4 Unk
Completed by	PARKINSONS DISEASE	24a. Was an autopsy performed? 24b. Were autopsy finding available prior to completion of deeth?
Be Con	25. Was case referred to medical	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 28. Plece of Death (Check only one)
To B	exeminer?	Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Certification:	Accident investigation M	Injury at 28d. Describe how injury occurred Work? 1 Yes 2 No
Certific	a Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offi building, etc. (Specify)	ice 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Medical	end manner stated.	my opinion, death occurred at the time, date and place, and due to the ceuse(s)
	30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)	JANUARY 21 19
	5: MAURER MO 9501 OLD ANNAPULIS RP	ELLICOTT CITY MO 21042
tate	31. Date filed (Month, Day, Yeer) 32 Registrar's Signature	-

Registrar

MAN 30 1998 July Davidson-Rondelle



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth EDDISON KIPP 9:10 pm January 27, 1998 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 805 Coxswain Way Unit 108 Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) Deys 18 M 2□ F 76 Yrs 079-03-9468 Dec. 2, 1921 New York Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊠Yes 2□No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 805 Coxswain Way Unit 108 21401 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 ☐ Never Merried 2 Merried 1 X Yes 2 No If Yes, Give Yeer or Detes: 1940-45 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Electrical Engineer Aerospace Engineering 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Eddison Winthrop Kipp Ethel Borst 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Joan Lunt - Daughter 9384 Diamondback Drive, Columbia, MD 21045 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetlon 3 □ Removei from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Memories Gardens Cemetery 2/2/98 Colonie, New York 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Anhapolis, MD alent 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) Due to (or es e consequence of) Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes an autopsy performed? 1 Yes No No 1 □ Yes 2 □ No 25. Was case referred to medical examiner?

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

Funeral

Director

show

r than "natural", or items 23a or 28a-f short the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer deeth v
Department of Heelth and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a enty Injury or other traumatic event, the Medical Examinat mass ance.

Baltimore, Maryland 21215-0020

with the Meryland

Physician/Medical Examiner ettending physicien end for use es the buriel-transit signed by the e ò hes certificate director Be 2 this

law requires that the death certificete be executed

Physician:

Anin 24 hours

To the Hos within 24 hd To the Fund completely

era

Certification:

edical

29e. Certifier

of Vital Records, P.O. Box 68760,

Division or Attending Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

1 ☐ Yes 2 No 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 1 Naturei 2 Accident 5 Pending investigation 6 Could not be 3 ☐ Suicide 4 Homicide

28b. Time of injury 28c. injury et Work? 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Yes 2 No

🖼 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the ceuse(s) end manner as steted.

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, end due to the cause(s) end manner stated. (Check only one) 29b. Signeture end title of cartifier in

1998

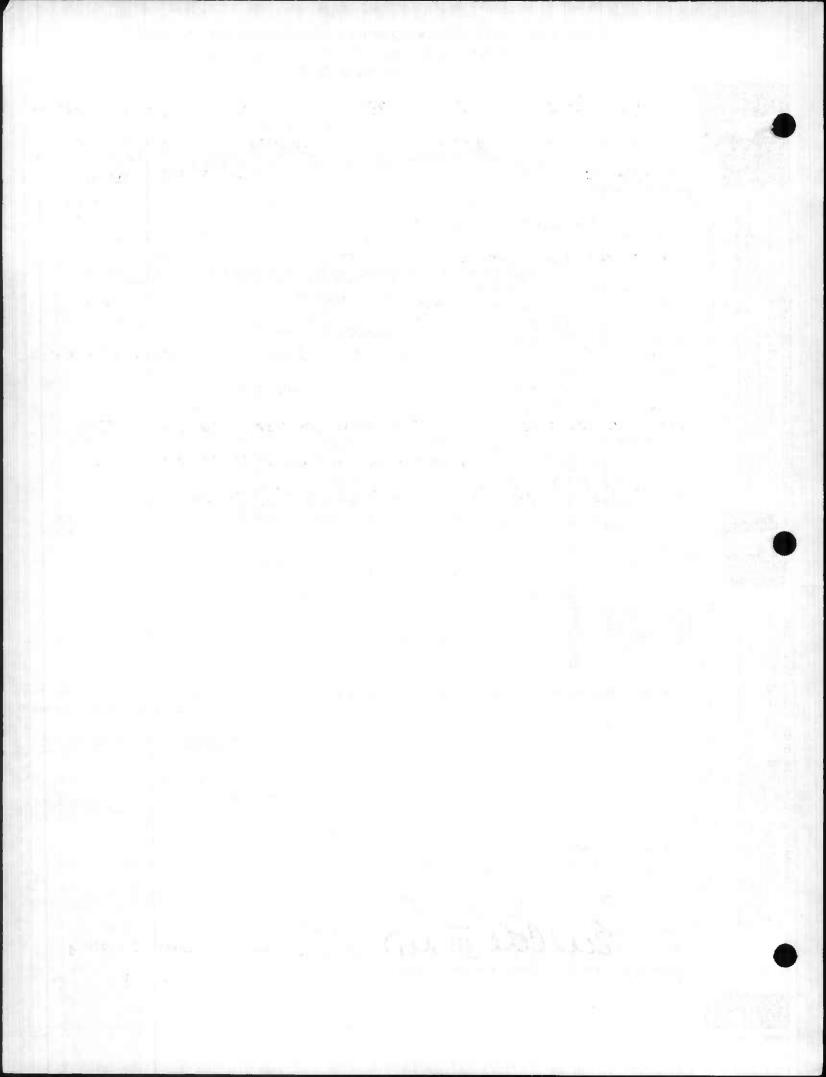
29c. License number 1635 29d. Date signed (Month, Dey, Year)

Annyootes

30. Name and address of person who completed cause of death (Item 23e) (Type Print)

32. Registrar's Signeture Julia Davidson-Rondoce

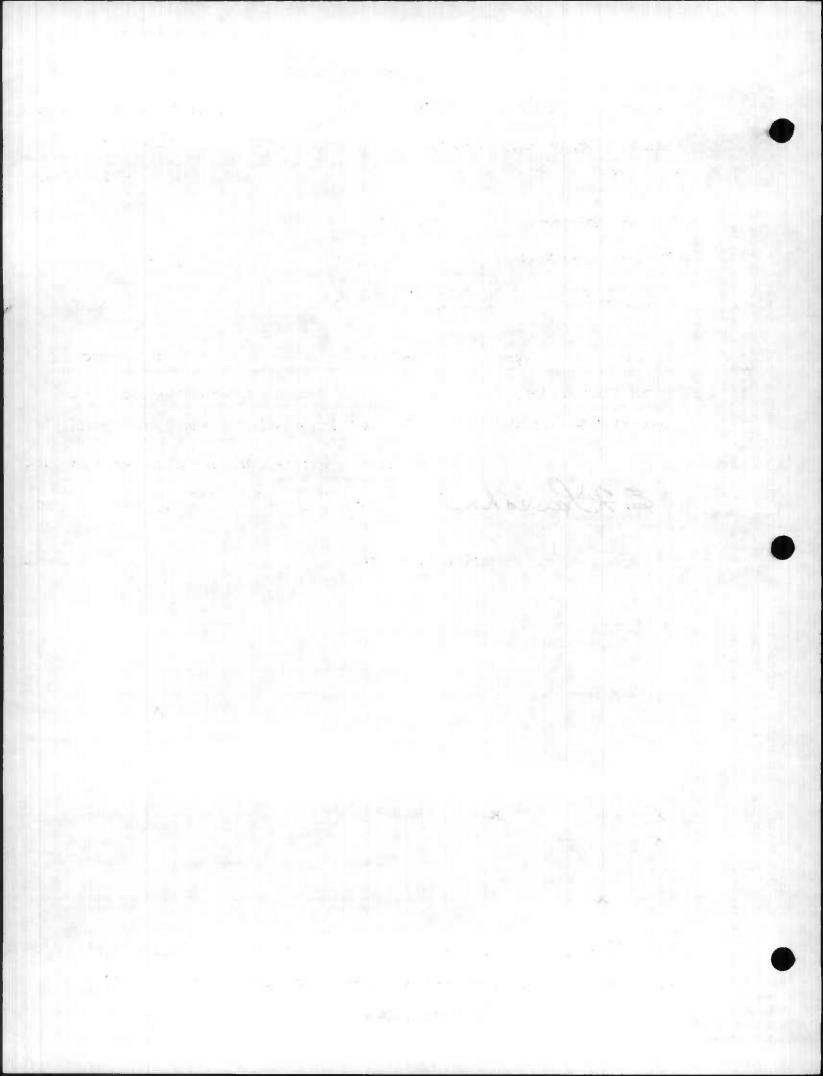
State Registrar



State of Maryland / Department of Health and Mental Hygiene

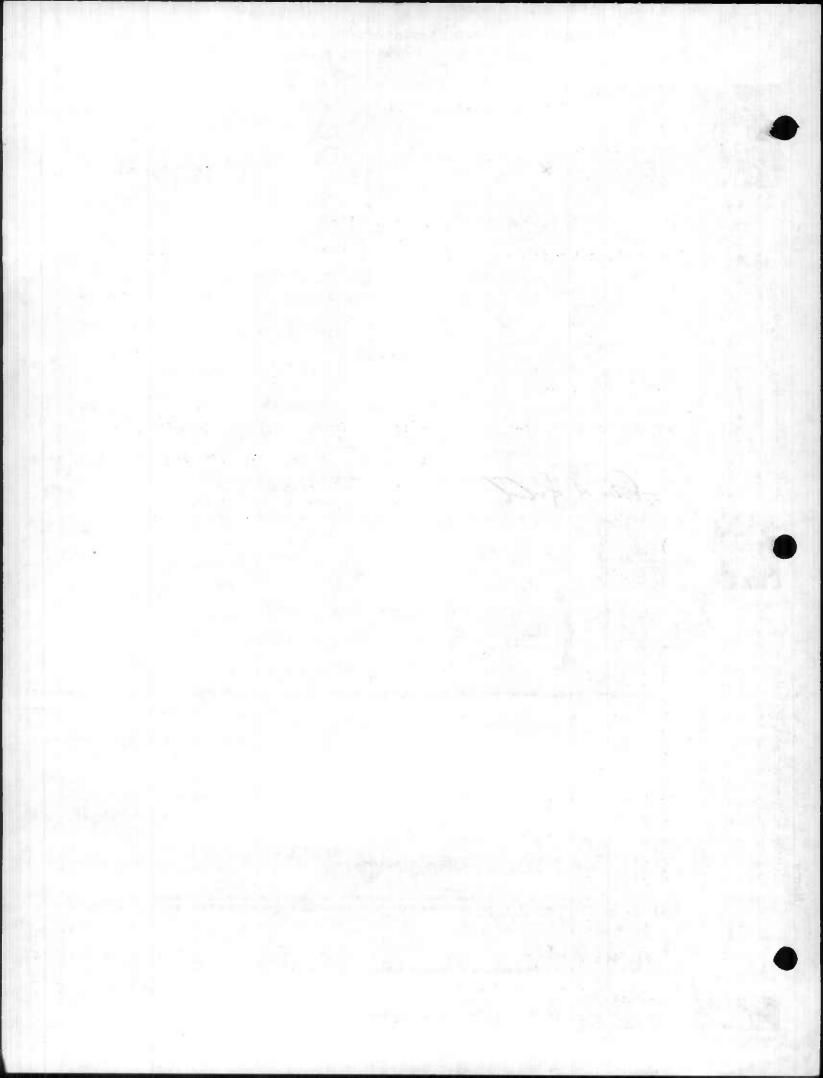
					Ce	rtificate o	f Death	R	eg. No.	UZI	434
П	1	1. Decedent's Name (First, Mid	dle, Last)				500	2. Date of Dea	th	Year	3. Time of Death
ш	Physician /Medical	Joseph	Clifton	K	IDD	Jr.		January	Day 27, 19		5:45 P.M.
	Examiner	4e Facility Neme (If not instituti	on, give street end i	number)			4b. City, Town, or	Location of Death	4c. County		
		Franklin Squa	are Hospi	tal Cent	ter		Rosedale	2	Balti	more	
	Funeral	5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday,	if Under 1 Yes			Year)	9. Birthplac	e (Stete or Foreign
	Director	215-32-1519	1⊠M 2□F	67	Yrs.	Indiana Bay	1102.0	Jan. 6, 19			re City, Md.
	2 ,	Usual Residence of Decedent 10a, State 10b, Coun		100 0	Mr. Town and					404	to alde Oby Limits
	anylar ahow	WI.			City, Town or L					100	. Inside City Limits 1 ☐ Yes 2 ☐ No
	oto		imore	Pe	rry Hal	L1					
	vith the Me tor 28s-fa be notified Director	10e. Streef end Number				10f. Zip Code		1	Og. Citizen of V	Vhet Counfry	?
	23a	4619 East Jopp	a Road			21128			U.S.A.		
- 3	72 hours after death with the Maryland natural, or Items 23s or 28s-f show oreal Exercises must be notified at seed by Funeral Director	11. Marital Status	Armed	ecedent Ever in Forces?	U,S. 13.	Was Decedent of Yes, specify Co	f Hispenic Origin? (Suban, Mexicen, Pue	Specify Yes or No- to Ricen, etc.)	14. Rac Blac	e - American k, White, etc	
50	or h	1 ☐ Never Married 2 ☑ Ma	rried 1 X Ye	s 2 No 10	/1/51	1□Yes 2XN	lo Specify:		Specify	<i>r</i> :	
00	ural', o	3 Widowed 4 Divorce	ed Yeer or	Dates: 9/30	/54					Wh	ite
21215-0020	ed within 72 hours ygiene. er than "natural", t, the worker Completed by	15. Decede (Specify only high	ent's Education est grede complete	d)	16e. Dece	dent's Usual Occ kind of work dor	supation ne duning most of wo ired)	orking	16b. Kind of Bu	siness/Indus	stry
12	filed within Hygiene. ther then ent, the Me	Elementary/Secondary (0-12)		(1-4or 5+)			190/		0 15 5	-	
7	Hygiene. ther than	12th. 17. Fether's Name (First, Middle	4yrs		Contr	ractor	18 Mother's No	me (First, Middle,	Self-En		1
and	B B B B										
2	2 should be filed and Mantel Hygi is marked other sumatic event, To Be Co	Joseph Clifto		r.	405 14011	ing Address (Con	Helen E	lizabeth_			arda l
=	2 4 4 5	19a. Informent's Name/Reletion									
	other tr	Margaret Kidd 20a. Method of Disposition	(Wife)	20h			oppa Road	Perry H	20c. Location -		
Baltimore,	S to L	1 Buriai 2 □ Cremation		m Stare		osifion (Neme of metory or other p					
	permit. Pag Depertmant Important: I any injury o	4 Donation 5 Other		Be.		emorial (1/31/98	BelAir,	Maryla	nd 21014
Sal	permit. Depertir Imports any init	21. Signature of Funeral Service	e Licenses	,	. 2	2. Name end Add		1 Hama			
ш	205 20	6.7	assa	hn	1	1750 Re	ssahn Fund Lair Road	Kingsv	ille M	larvla	nd 21087
-		23a. Part1. Enter the disease, shock, or heart failure. Li	or complications the	t ceused the de	ath. Do not en	ter the mode of o	lying, such as cardia	c or respiratory arr	est,	A	pproximate iterval Between
F	hysician									C	Inset and Death
2	/Medical	Immediate Cause (Final disease or condition	Myzo	cardia1	Infar	ation				1	5 Minutes
1	Examiner	resulting in death)	e		(or es e conse						J_HIHULES
-		HILLS AND A									
	rificate be executed ng physician and i as the buriel-transit Medical Examiner	Sequentially list conditions,	6	Due to	(or as a conse	quence of):					
o	ian a uriel-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								1	
68760	physicia s tha bu	thet initiated events resulting in deeth) Lest	°.	Due to	(or as a conse	quence of):					
	5 5 5										
Вох	attendin for usa		d								
	The law requires that the death certive has been signed by the attending page 2 should be deteched for use a Completed by Physician/M	Pert II. Other aignificent condi	tions confributing to	deeth buf not re	sulfing in the I	underlying cause	given in Part I.	23b. Did to	obacco use co	ntribute to ti	he cause of death?
P.0	res that the de igned by the a dateched by Physic							101	as 2 No	3 Proba	bly 4 Unknown
'n	be de de de de de de									,	
פֿ	bean signature should t							24a. Was e	en eutopsy med?	24b. Were availa	e eutopsy findings able prior to
Record	s be s be s be s							, po		comp of de	oletion of ceuse
m i	Tha law requirements to be a set of the set							1 U Y	es 2 No	10	Yes 2□ No
		25. Was cese referred to medic	eal				26. Plece of De	eath (Check only or			
>	P	examiner? 1 X Yes 2 □ No	Hospitel:	Inpatient 2	☐ ER/Outpatie	ent 3 DOA	Othor	Home 5 ☐ Resid		er (Specify)	
ō	rthis aral c	27. Menner of Deeth		te of Injury onth, Dey Year)	28b. Time (njury et Vork?	28d. Describe h			
0	th. After	1 Natural 5 Pend 2 Accident Inves	ling (M stigation	onth, Dey Year)	injury		Yes 2 No				
2	be or Attending P is after death. Be Director: After t ad in by the funara Certification:	3 ☐ Suicide 6 ☐ Coul	mined 269. Pla	ace of injury - At	home, farm, st	treet, factory, offic	ce		treet end Numb	per or Rural I	Route Number,
Division	after Dire	4 Homicide	bui	ilding, etc. (Spec	cify)			City or Tow	n, Stete)		
		29e. Certifier 1X Cartify	ing Physician: To t	the best of my kr	nowledge, deel	th occurred et the	time, date and pled	e, end due to the o	euse(s) and ma	anner es stet	ed.
	he Hosp in 24 hou he Funer pletaly fil edical	(Check only 2 Medical	I Examiner: On the	basis of examinance stated.	nation and/or in	nvestigation, in m	y opinion, deeth occ	curred et the time, o	date end place,	end due to the	ne ceuse(s)
- 0	ithin of the omp	29b. Signature and title of certif	ier		700	29c. Lice	ense number		29d. Date signe	d (Month, De	ey, Year)
	- 3 F Ö		ac m	19		A	24389	46	1-27	-05	
)	NH.						~ 700/		· « /	70	
	1407	30. Name end address of person Dr. Edward Mo					r. Baltim	ore. Mar	yland 2	1237	
	State	31. Dete filed (Month, Day, Yea		Registrar's Sig							
			0.2	11. 20	. 4						

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

					Certifi	cate of	Death		Reg. No.) U	C 4 0 .)
Physician	1. Decedent's Na	ame (First, Middle, Li		4117	-			2. Dete of D Month		Yeer	3. Time of	Deeth
/Medical			eorge Will	liam L	eare			dan	28	98	4:00	am
neral ector	C has 5. Social Security 164-09	y Number 6.		(In yrs. last bil	rthday) If	Under 1 Year onths Deys		Hrs. 8. Date of B		9. Birther Penn	mort plece (Stete on ntry) ISY1van	rForeign iia
To Be Completed by Funeral Director	Jsuel Residence 10a. Stete	10b. County		10c. City, Tow	n or Locatio	n					10d. Inside Ci	
rector	MD	Balt:	imore	Ca	tons	ville					1 🗆 Yes	No No
Direc	10e. Street end h		oice Ln. N			0f. Zip Code 2122			10g. Citizen o		ntry?	
by Funeral Director	1 Never Ma		12. Was Decedent Ev Armed Forces? 1 Yes 2F No If Yes, Give Yeer or Dates:	er in U,S.			Hispanic Origin ban, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	lo- 14. R	ace - Americ leck, White, city: Wh	etc.	
		15. Decedent's E	ducation	16a	. Decedent's	s Usuel Occu	petion	d washing	16b. Kind of	Business/In	dustry	
Completed		pecify only highest greecondery (0-12)	ede completed) College (1-4or 5+)				during most o	r working				
S				Sa	lesm	an				ıranc	е	
To Be		ne (First, Middle, Las .iam Leyl						s Name <i>(First, Middi</i> Elsie Ha		eme)		
-	19e. informent's	Name/Reletionship	(Type, Print)	198	o. Mailing Ad	ddress (Stree	et end Number	or Rurel Route Num	ber, City or Tow	vn, Stete, Zip	o Code)	
To Be Comp	20a. Method of D		ughter Removel from State	20b. Plece o cemete	of Disposition ony, cremetor	n (Neme of ny or other pl	ece)	licott Ci	20c. Location	n - City or To	own, State	
9	4 Donetion	n 5 Other (Speci	fy)	Crest	22 Na	me end Adde	ess of Fecility	02/02/98		ottsvi	lle, M	D
once.	Edwa	The state of the s	gorchik oplications that caused the		301	Frede	rick Rd	Home, P.A. Baltimo	re, MD	21228		
edical Examiner	Immediete Ceus diseese or cond resulting in deet	ition	e. End D	5 fag ue to (or as e	e f	Purk (nson's	Disea	se		7 Eur	18
Medicai	Sequentielly list if eny, leading to cause. Enter Un Ceuse (Diseese that initieted everesulting in deeth	ints	С.	ue to (or es e								
Physician	Pert II. Other sig	nificant conditions	contributing to death but	not resulting i	in the under	lying cause g	iven in Pert I.	23b. DI	d tobacco use	contribute t	o the cause (of death?
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ed in by the funeral Certification:	27. Menner of De 1 ☑ Naturel 2 ☐ Accident	5 Pending Investigation		Yeer) 28b.	Time of Injury	28c. Inj W 1	ury et ork? □ Yes 2 □ No	0	e how Injury occ			
Certific	3 ☐ Suicide 4 ☐ Homicid	6 Could not I	28e. Place of Injury building, etc.	y - At home, fo (Specify)	erm, street,	factory, office		28f. Location City or T	(Street end Nu. own, Stete)	mber or Run	el Route Num	ber,
Medical Cert	29a. Certifier (Check only one)		hysicien: To the best of miner: On the besis of e end menner stets	xamination er								;)
×	29b. Signeture e	nd title of certifier			4	29c. Licer	nse number		29d. Dete sig	ned (Month,	Dey, Year)	
	fr	her In	af 1	10	(Turn Dala)	0	5105	(atonsvi)	Janua	119	28 1	998
	Andre	1 Salazo	completed cause of dee	aiden	Cleo	ice 1	ane,	Catonsui	lle, M	2, 2	-1229	3
State Registrar	31. Dete filed (M	JAN 3 0 1	998 32. Registrar	's Signeture	n-Rand	all						



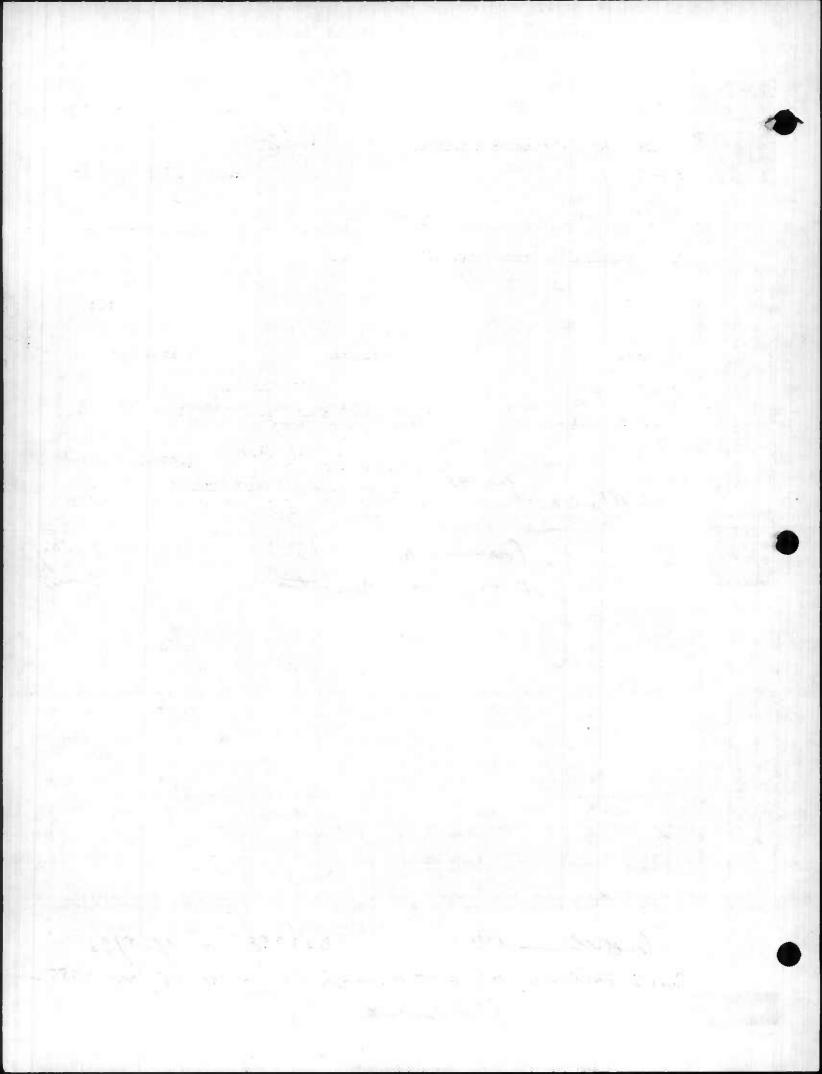
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth **Physician** Month Veer LEVINE January 25, 1998 8:10 A.M. /Medical 4e. Fecility Name (If not institution, give street end number) Rockville

| House | Hours | Min. | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockville | Rockvi 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Hebrew Home Of Greater Washington Montgomery 9. Birthplece (Steta or Foreign Country) Russia 7. Age (In yrs. lest birthday) **Funeral** 1□ M 2XF Yrs. Director 99 578-07-6200 Usuel Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show 7 is marked other than "natural", or itams 23a or 28a-f shov traumatic event, the Medical Examiner must be notified as Montgomery Silver Spring 1 AYas 2 No Maryland Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20906 U.S.A. 15101 Interlachen Drive, Apt. 918 death Funeral 12. Wes Decedent Ever in U.S. Armed Forcas? 14. Race - American Indien, Bieck, Whita, atc. Was Decedant of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 72 hours after 1 Never Merriad 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detas: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p Specify: 3 ™ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than any injury or other traumatic avant Elementery/Sacondery (0-12) Collaga (1-4or 5+) United Jewish Appeal Bookkeeper 12 Years 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Surneme) Be Elke Strelsin 0 Shmuel Bercov 19a. Informant's Neme/Relationship (Type, Print) 19h Mailing Address (Street and Number of Rural Route Number of Theor Town, Steta, Zip Code) 15101 Interlachen Drive, Apt. Silver Spring, Maryland 20906 Daniel B. Levine, Son Maryland Silver Spring, 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 1/28/1998 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, Maryland Mount Lebanon Cemetery 22. Nama and Address of Fecility
STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee m00544 232 CARROLL STREET, NW, WASF
23a. Pert1. Enter the disease, or comprisations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only the ceuse on each line. 232 CARROLL STREET, NW, WASHINGTON, DC 20012 Approximete Intarval Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in death) **Examiner** hermen pue Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Ceuse (Disaase or Injury that initiated avants resulting in deeth) Lest Due to (or as a consequence of) Box 68760. physicien Physician/Medical the Due to (or es a consequence of) ettending p Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. sate hes been signed by the page 2 should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □ Unknown Records, p 24b. Were eutopsy findings eveileble prior to completion of cause of daeth? Be Completed 24e. Wes en eutopsy performed? 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours efter deeth. 25. Wes case referred to medical exeminer? 26. Pleca of Daath (Check only one) Other: Surring Home 5 Residence 6 Other (Specify) 1 Yes 25 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Date of Injury (Month, Dev Yeer) 27. Maryner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 5 Pending invastigation Netural 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Couid not be datermined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homlcida hin 24 hours e the Funarai D npletely filled Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. edicai 29a. Certifier To the Within 2.
To the F 29b. Signeture and title of certifier 29c. Licansa numbar D23958 30. Name and eddress of person who completed causa of death (Itam 23a) (Type, Print)
Burn T. Ferdonion, MD 6/05 Mon Montrose Rds, Rockvile, 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State JAN 3 0 1998 Registrar

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 21 Per Anatomy Board Film G-755 1-30-98RCv 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MARGARET 24,1998 January 5:00 am /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital & Medical Center Cumberland Allegany 8. Date of Birth (Month, Day, Year) Nov. 18, 1918 5. Social Sacurity Number If Under 1 Year If Under 24 Hrs. 7. Aga (In yrs. last birthday) 6. Sex **Funeral** 1□M 2⊠F Months Days Hours Min Yrs. Director 219-58-7827 unknown Usual Residence of Decadent the Marylend 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot treumatic event, the Mackal Examiner must be nothed at 1 ☐ Yas 2 € No Maryland Director Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 Holland Street 21502 U.S.A. death Funeral 12. Was Dacedant Evar in U.S.
Armed Forcas? unknown
1 □ Yes 2 □ No
If Yes, Give
Year or Dates: 11. Marital Status unknown Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - American Indian. Black, White, etc. filed within 72 hours efter Hygiane. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify by 3 ☐ Widowed 4 ☐ Divorced Completed 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) permit. Pages 1 end 2 should be filed within Department of Health end Mentel Hygiene. Important: If item 27 is marked other than any injury or other traument. Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patty Everding/daughter unknown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 XDonation 5 Other (Specify) WADE, DIRECT Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street 21. Signature of Juneral Service Licensee RONALD S. Baltimore, Maryland 21201 iller 23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction One Day Examiner Due to (or as a consequence of): Examiner be axecuted the buriel-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): physician Physician/Medical Dua to (or as a consequence of): as attending o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? been signed by the s should be detached 1 Ves 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease. þ 24b. Ware autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed page 2 has 1 ☐ Yes 21 No 1 ☐ Yes 2 No certificata Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Propatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 20 No 2 this funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Medical Certification: After 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident by the 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760, Records. Division of Vital si or Attending s after death. ii Director: Aft Hospitai

To the Hospital within 24 hours a To the Funeral C completaly

JAN 3 0 1998

certifian

29c. Licansa number D 36766

1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

1998

January 🛂

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Dr. Vik Poonai-955 National Highway-LaVale, MD 31. Date filed (Month, Day, Year)

State Registrar

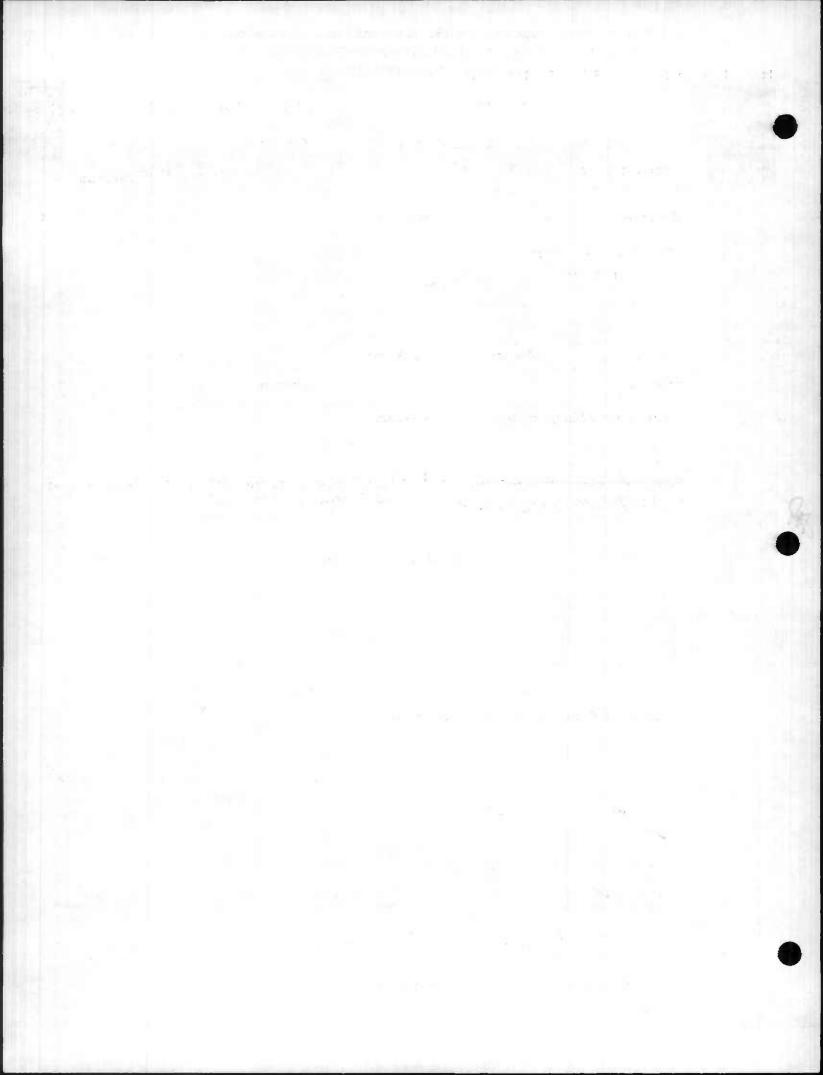
29a. Certifier

(Check only one)

29b. Signatura and title of

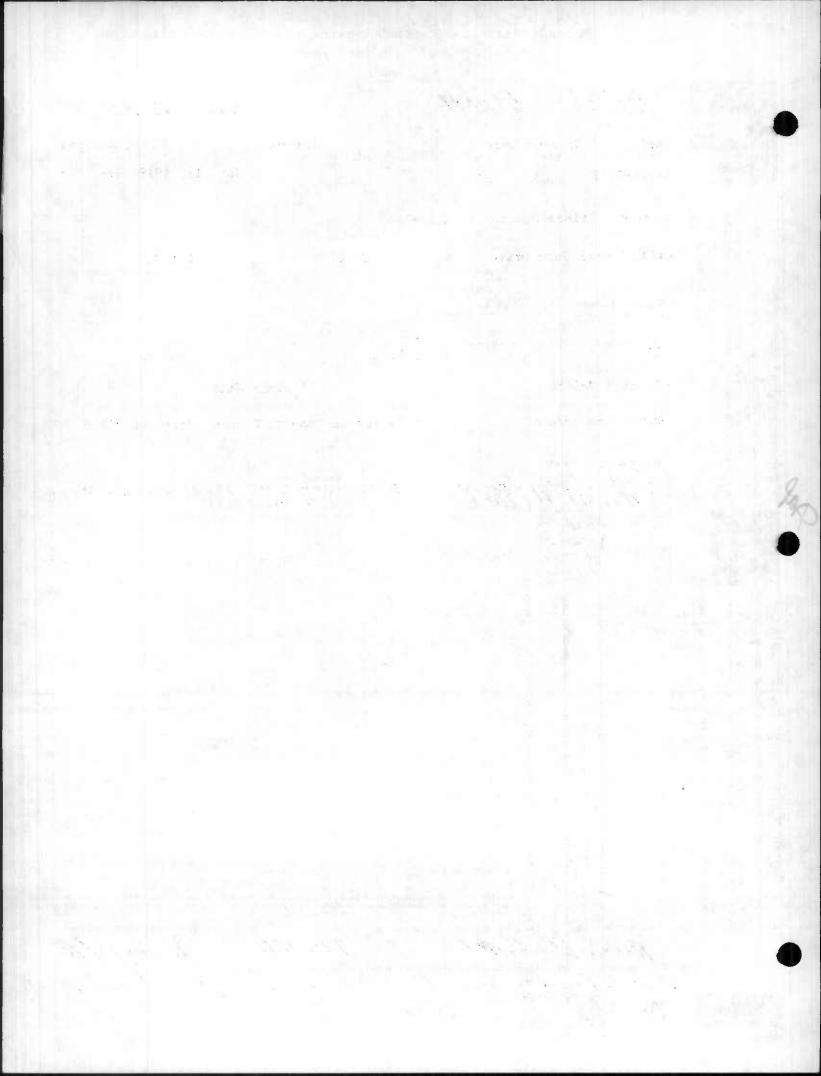
32. Registrar's Signature

and mannar stated.



State of Maryland / Department of Health and Mental Hygiene 8 02438

					Certific	cate of	Death		Reg. No.	02430
Physici		1. Decedent's Name (First, Middle, Las	LAMAR.	R				2. Dete of De Month	eeth Dey	Yeer 43 Mm
/Medic Examir		4a. Fecility Neme (If not institution, give					4b. City, Town, o	r Location of Dee	-	of Deeth
		Mariner of Great 5. Social Security Number 6. So		vrs last hirt	thotavi If L	Jnder 1 Yeer	Laure1	'S. 8 Date of Ri	Princ	ce Georges 9. Birthplace (State or Foreig
Funeral Director			□M 2□XF 79		Yrs. Moi	nths Deys	Hours Mi	Jan.	th ay, Year) 11, 1919	Country) Iowa
dand dand		10e. State 10b. County	10c.	City, Town	or Location	n				10d. Inside City Limits
Many Feb	to	Maryland Prince	Georges	Laure	1					1 ☐ Yes 2 ☑ No
death with the Maryland ms 23a or 28a-f show	I Director	10e. Street end Number 14200 Laurel Par	k Drive		10	of. Zip Code 20707			10g. Citizen of V	What Country?
Jeath 1	Funeral	11. Marital Status	12. Was Decedent Ever i	n U,S.	13. Was [Decedent of I	fispenic Origin?	Specify Yes or N		e - American Indien,
ē 2 3	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Wildowed 4 ☐ Divorcad	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes,	, specify Cub es 2⊠ No	en, Mexican, Pue	orto Rican, etc.)	Bled	ck, White, etc. V: Black
2 ho	ted	15. Decedent's Ed		16e.	Decedent's	Usuel Occup	oation	. 4.1	16b. Kind of Bu	usiness/Industry
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ntai I	Be	Clarence Weldon						la White	, maiden damen	10)
should be ind Mental marked o	10		0200	100	A4 95 A 1				- O: T	0 7. 0
d 2 sl h an r ls n traur		19e. Informant's Name/Relationship (7 Norman Lamarr/s						Rurel Route Numi	-	
somit. Pages 1 end 2 should be filed within 72 hours after a programment of Health and Mental Hygiene. The marked other than "natural", or my injury or other traumatic event, the Heal cal Event Ance.		20e. Method of Disposition		b. Plece of	Disposition			Lanham,		d 20706 City or Town, State
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Physician /Medical Examiner	ier	21. Signature of Fundral Service Licent Ronald S. Wad S. W	licetions that caused the done couse on each line.		Balt	imore mode of dyl	Maryla	nd 21201 ec or respiretory		Approximate Intervel Between Onset end Deeth
eath certificate be executed ettending physiclen end for use es the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest	c	o (or es e c	consequence	e of):	neon			Tylest
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thet the death ce ned by the ettendii	/ Physician/	Part II. Other significant conditions co	ntributing to deeth but not	resulting in	the underly	ing cause gr	ven in Pert I.		Yes 2 No	ntribute to the cause of death 3 Probably 4 Unknow
aw requires s been sign 2 should be	Completed by								s en eutopsy ormed?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?
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ysician: The	Be (25. Wes case referred to medical					26. Plece of D	eeth (Check only	one)	
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To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Phy	sician: To the best of my iner: On the basis of exemend menner steted.	knowledge, Inetion end	death occu	urred et the ti etion, in my d	me, dete end plea opinion, deeth occ	ce, end due to the	ceuse(s) end me date end place,	anner es steted. and due to the cause(s)
ompl	Me	29b. Signature end title of certifier				29c. Licens	se number		29d. Date signe	d (Month, Dey, Yeer)
- > - 0		Medew Ree	celestus			15	67/6		June	ug 26/98
		30. Name end eddress of person who of ANDREW FURNISHED		Item 23a) (Type, Print)	Cho	11010 1	dos	laurel	4 26/98 Med. 20107
Sta	te	31. Dete filed (Month, Day, Year)	32. Registrer's Si	gneture	//	ME	0 0	Conce /	Au /e/	pag. 20101



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Nama (First, Middle, Last) 2. Data of Death January 27, 1998 ANNA. V. LOCKMAN 4e. Fecility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Baltimopl City ar If Under 24 Hrs. 8. Data of Birth Min. (Month, Day, Year) Hospital maryland General 5. Social Security Number If Undar 1 Yaar 6. Sax T. Age (In yrs. lest birthday) Birthplaca (State or Foreign Country) 10 M 20 F Days 219-30-725 93 Yrs MARYLAND 10,1904 June Usual Rasidanca of Decedan 10b County 10c. City, Town or Location 10d. Insida City Limits 1 Yea 2 No BALTOO CIL 10e. Straat and Numbar 10f. Zip Code 10g. Citizan of What Country? FRANKLIN ST. 10-616 U.S.A w. Was Decedant of Hispenic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Raca - Amarican Indien, Black, Whita, atc. 11. Marital Status 1 Nevar Merried 2 Marriad 1 Yes 2 No If Yas, Giva Yaar or Datas: 1 ☐ Yas 2 ☐ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) College (1-4or 5+) HOSPITAL 3RD GIRANING Person. CHUrch NIA 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) LOCKMAN KobeRT LUCKAN MARY 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) STIERSTORFER 160Y BACTO, MD 31306 . €. AVE 015 & CHODALE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata of FAITH COM. 1-29-98 BALTO. MD 4 ☐ Donetion 5 ☐ Othar (Specify) GARDENS 22. Nama and Addrass of Facility Miller Funeral Home 21. Signatura of Funaral Service Licensaa 23a. Part1. Enter the disease, of complications that caused the deeth. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line. Miller BALTO MD Approximate Intarval Batwaan Onset and Death Pneumonia Immediate Ceusa (Final diseesa or condition rasulting in death) Due to (or as a consequence of):

Physician /Medical Examiner

the buriel-transit

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ate hes been signed by the ettendin page 2 should be deteched for use

this certificate

After

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24 hours Hospitai

To the Vithin 2

director.

the funeral

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by

Be Completed

Certification: To

Medical

pue

or Attanding Physician: The law requires thet the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

permit. Pege Depertment of important: If any injury or

Physician

/Medical

Examiner

10a. Stata

Director

Completed by Funeral

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Funeral

Director

nit. Peges 1 and 2 should be filed within 72 hours after death with the Marylei entment of Health end Mental Hygiene. ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified as

Baltimore, Maryland

Examiner Sequantially list conditions, if any, laading to Immediata cause. Enter Undarfying Cause (Disaase or injury that Initiatad avents rasulting In death) Last Physician/Medicai

Due to (or as a consequence of):

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were eutopsy findings available prior to completion of cause of deeth?

1 Yas 2 No

26. Place of Deeth (Check only one)

1 ☐ Yas 2 ☐ No

25. Was casa rafarrad to medical examinar? 1 Yas 2 No

28a. Date of Injury (Month, Dey Year)

28b. Tima of

28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

1 Inpatiant 2 ER/Outpatiant 3 DOA 28c. Injury at Work?

Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 28d. Dascribe how injury occurred 1 ☐ Yas 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifian (Check only one)

27. Manner of Daath

1 Natural

2 Accident

4 - Homicida

3 ☐ Suicida

**Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examinar: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and menner stated.

29b. Signature and little of o

5 Pending investigation

6 Could not be datamined

29c. Licansa number

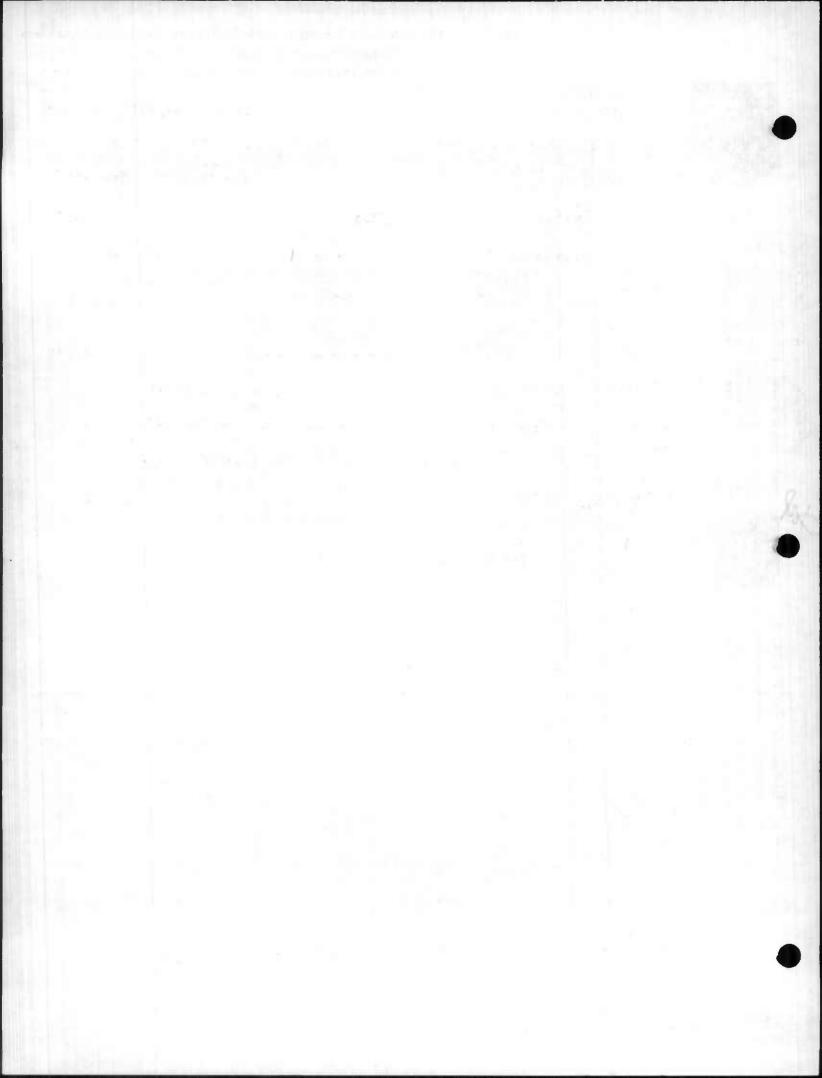
29d. Data signed (Month, Dey, Year)

30. Nama and eddrass of person who complated causa of death (Item 23a) (Type, Print)

General maryland 40 31. Data filed (Month, Dey, Year)

State Registrar

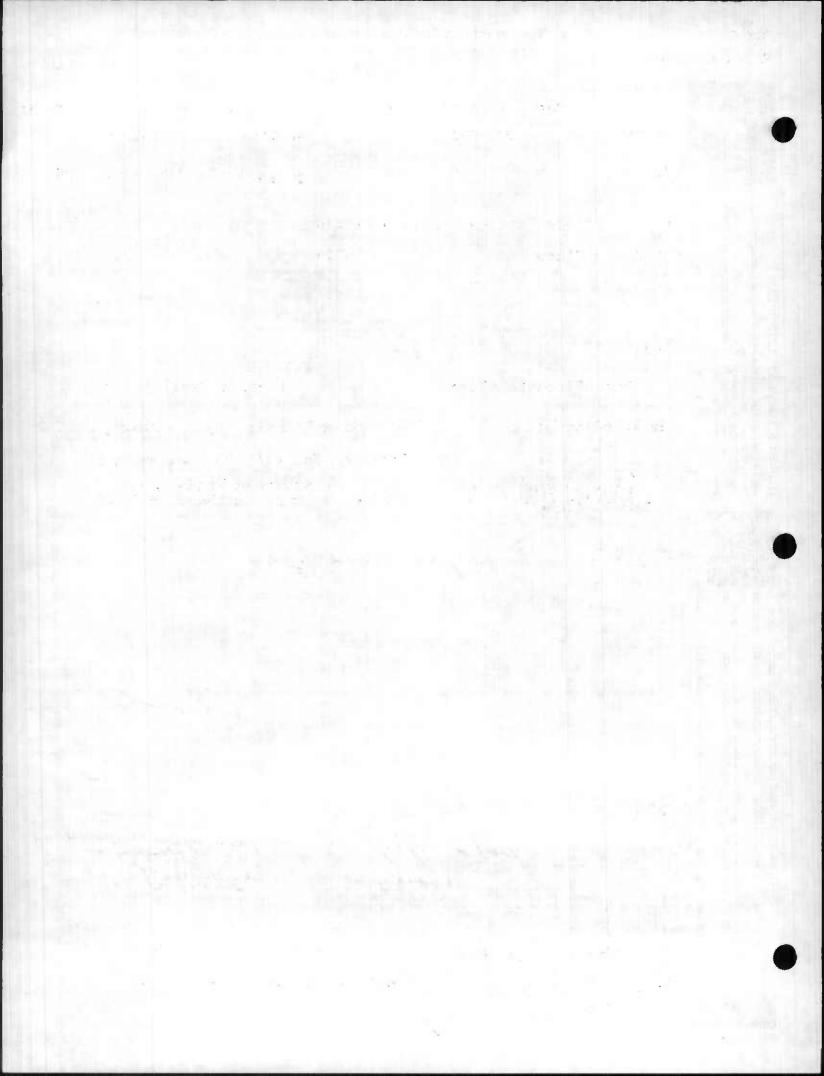
32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

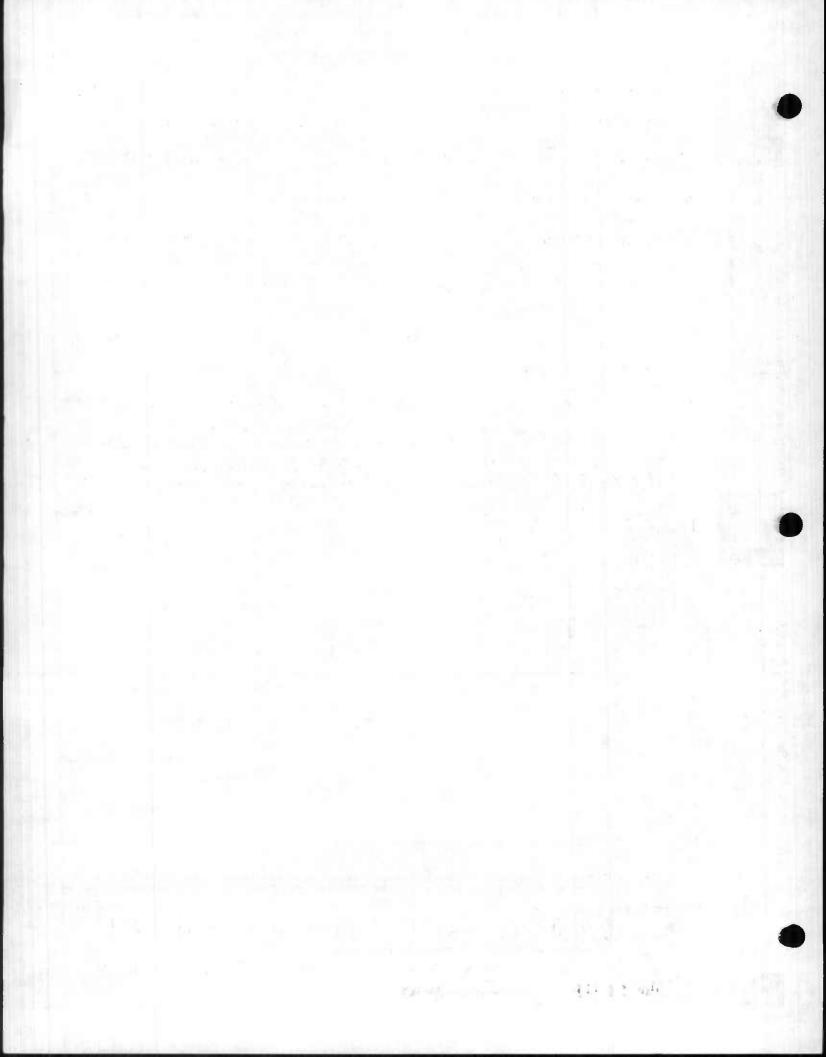
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	. ,	1. Decedent's Name (First, Middle, Las	()				2. Date of Deet Month		Yeer 3. Ti	ime of Deeth
Physic /Medi		Mai	rquel David	Mollon			JAN.	26, 199		1850 PM
Exami		4a Facility Name (If not institution, give PENINSULA REGIO	street and number) VAL HOSPITAL		41	SALISBUR		4c. County WICO		
Funeral Director		5. Social Security Number N / A Usuel Residence of Decedent	7. Age (In yrs.		Under 1 Year onths Days	Hours Min.	8. Date of Birth (Month, Dey) JAN 26,	Year) 1998	9. Birthplece (S Country) Maryla	_
/land		10a. State 10b. County	10c. Cit	ty, Town or Location	on .				10d. ins	ide City Limits
Man	tor	MD Prince	Georges U	pper Ma	r1boro				1 🗆	Yes 2NNo
or 28	Sire	10e. Street end Number			Of. Zip Code		1	0g. Citizen of V	Vhet Country?	
ath w	rai	605 Dwyer Place			20774				SA	
parmit. Peges 1 and 2 should be filled within 72 hours after death with the Maryland Depertment of Health and Mantal Hygiena. Important: If Item 27 is marked other than "naturel", or items 23a or 28e-f show any Injury or other treumetic event, the Madical Evantive must be notified at mantales.	by Funeral Director	11. Merital Stetus Never Married 2 Merried Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates:			spenic Origin? (Spen, Mexicen, Puerto I	Ricen, etc.)		e - American Indi k, White, etc.	
72 ho	Completed	15. Decedent's Edi (Specify only highest grad		16e. Decedent's	s Usual Occupe	tion u <i>ring</i> most of worki	na	16b. Kind of Bu	siness/Industry	
d 2 should be filed within 72 hours af the and Manial Hygiena. 27 is marked other than "naturel", or treumatic event, the Medical Exami	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	VOT use retired,			27 / 4		
Hygie Hygie ther ti	S	N / A 17. Fether's Neme (First, Middle, Last)		N/A		18. Mother's Name	(First Middle I	N/A	e)	
d be of the contain the contai	o Be		ent Mollon				ree Ez		-,	
should be nd Mental marked o	To	19e. Informent's Name/Relationship (T		19b. Mailing Ad	ddress (Street e	nd Number or Rura				
and 2 saith e n 27 le		Mark V. Mollon/fa	ther	1208 He	eritage	Hills Dr	. Uppe	r Marlb	oro. MD2	20772
vermit. Peges 1 a Department of Hee mportant: If Nem iny Injury or othe		20a. Method of Disposition 1 Duriai 2 Cremation 3 Di	20b. F	Place of Disposition	n (Name of ny or other pleci	9)	Date	20c. Location -	City or Town, St	ate
Peges ment of I ant: If Ite ury or o		4 Donetion 5 Other (Specify	Met			nc. 01/2		Baltimo:		
permit. P Depertment Importan any Injur		21. Signature of Funeral Service Lipens	1ex-mald	22. Na Cre 299	me and Address mation Freder	Society of rick Rd. 1	of Maryl Baltimon	land, In	nc. 21228	
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rifficeta be executed was no physician end was the bunal-transit as	Medical Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last	cDue to (o	or es e consequend	ce of):					
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requir	Completed by					1.29	24a. Was e		24b. Were eut available completic of death?	prior to on of ceuse
ulcian: The law cartificata hes b irector, page 2 s	E O						194	es 2 No	1 □ Ye s	2□ No
ician: The cartificata rector, pag	Be	25. Was cese referred to medical exeminer?				26. Place of Deeth	(Check only or	10)		
Physics this ca	10	tXXVes 2□ No		ER/Outpatient 3		4 LI Nursing Ho	-			
dling P. After funer	ion:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	res 2 PNo	28d. Describe h		s a pedes	strian
or Attanofiter deet Sirector: in by tha	Certification:	2 Accident investigation 3 Sulcide 6 Could not be determined	286. Place of Injury - At h- building, etc. (Specif	ome, ferm, street,	factory, office		281. Location (S City or Tow Siant Food	Store par	er or Rurel Rout	e Number,
To the Hospital within 24 hours error to the Funeral Completely filled	edical (valcian: To the best of my kno iner: On the bests of examina and manner stated.				end due to the c	ause(s) end ma		euse(s)
of the omple	Mec	29b. Signature and title of certifier	and mainer stated.		29c. License	number	2	9d. Dete signe	d (Month, Dey, Y	'ear)
DH		· Denni	2 Chuten		o.c.	M.E		JAN. 2	27, 1998	
		30. Name end eddress of person who	/ - 11			Baltimore	e, Maryl	and 212	201	
St	ate	Jennis J. Ch. 31. Date filed (Month, Day, Year)	32. Registrar's Signa				1-			
01		TAN 3 U	1000 \ 4.0.	M. L						



State of Maryland / Department of Health and Mental Hygiene

				Cei	rtificate of	Dealli	R	eg. No.	0 - 1 - 1
Physicia	an	1. Decedent's Name (First, Middle, Las	1)				2. Date of Dee	th Day Yea	3. Time of Dee
/Medic	al	Harold P. Matt				4b. City, Town, or L	Jan.	24, 1998	9:55 A
Examin	er	2546 Lavall Cour				Davidso		4c. County of De	
Funeral Director		5. Social Security Number 6. Se	ex 7. Age (/n y	yrs. last birthday) 70 Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs.	8. Dete of Birth (Month, Day		Birthplace (State or Fo
A ti		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Li
ried in	to	Maryland Anne Aru	ındel	Davids	sonville				1 □ Yes 24□
23s or 28	ral Director	10e. Street and Number 2546 Lavall Cour	et .		10f. Zip Code 2103	5		Og. Citizen of What C United St	•
Hygiane. the than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be northed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorcad	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 44-		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispenic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, hite, etc. Thite
natur lical i	ted	15. Decedent's Edu (Specify only highest grad	ucation	16a, Decad	dent's Usual Occup	pation		16b. Kind of Busines	
than °r	Completed	Elementary/Secondery (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most of work	my		
Hygiar other th		17. Fether's Neme (First, Middle, Last)	5+	Eng	gineer	10 Mathada No			se Corpor
o do	m	The same of the sa	- Cr			18. Mother's Nam			
	2	Harold P. Matters 19a. Informent's Neme/Relationship (T)		19b. Mailir	ng Address /Street		G. Ryar	City or Town, State	. Zip Code)
E		Margaret C. Matter	•					le Maryla	
item 27 i	-	20a. Method of Disposition	208					20c. Location - City of	
nant (int: if iry or		PBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)				1 Gardens			.11e Maryl
Department of Healt important: if Item 27 any injury or other t once.		21. Signature of Funeral Service Licans	Company of the Compan	22	2. Name and Addre				
		MUChaeld	Delm	/ 1	16000 Ann	apolis Rd	. Bowie	Maryland	
ysiclan	8	23a. Part1. Enter the disease, or composhock, or heert failure. List only o	ine caused the di	eath. Do not ente	ter the mode of dyl	ng, such es cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Deat
Medical		Immediate Cause (Final		~					10. 6
aminer		disease or condition resulting in death)	a. Plenin	o (or es a conseq	quenca of):				+ 10 yrs
**	iner				,				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	o (or as e conseq	quence of);				
s tha bu	0	Cause (Disease or Injury that initiated events resulting in deeth) Last	c. Due to	o (or as a consequ					
	0				quence or):				
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a attending ed for usa a	siclan/Me	Part II. Other eignificant conditions con		esulting in the ur		ven in Part I.	23b. Did to	bacco use contribu	Ite to the cause of de
gned by tha attendir be datached for usa	Physician/			resulting in the ur		ven in Part I.	23b. Did to		
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ata has been signed by tha attendir page 2 should be datached for usa	Be Completed by Physician/	Part II. Other eignificant conditions condit	ntributing to death but not r		nderlying cause gh	26. Plece of Deal	1 □ Yo 24a. Was a perform 1 □ Ye h (Check only on	n autopsy 24b ned? 24b	Probably 4 Unker D. Were autopsy finding available prior to completion of cause of death? 1 Yes 2 No
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		Decedent's Nama (First, Middla, and American State	ast)		Cei	rtificate of	Death	2. Data of D	Reg. No.	1 02	Time of Dooth
Physic /Medi		DESIREE WALKE		LEY				Month Januar	Day	Year 1998	. Tima of Death
Exami		4e. Facility Nama (If not institution, g UNION MEMORIAL					4b. City, Town, or L	ocation of Dea	th 4c. County		
Funeral			Sax	7. Aga (In yrs.	last birthdey)	If Under 1 Year		8. Data of Bi	N/A		(Stata or Foreign
Director	Г	215-66-0264	1□M 2X□F	42	Yrs.	Months Deys	Hours Min.	8/197	1955	RICHMO	ND, VA.
* **		Usual Rasidance of Decedant 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation		-		10d.	Insida City Limits
rms 23a or 28a-f show	ctor	MARYLAND		В	ALTIMO	RE					Y□Yas 2□No
or 28	Director	10e. Street end Number				10f. Zip Coda			10g. Citizen of	What Country?	
or items 23a or 28a-f show miner must be notified at	Funeral	506 EAST 26 STRE	12. Was Dac	edant Evar in U	,S. 13. V	21218 Was Dacedent of H	Hispanic Origin? (Sp	pacify Yes or N	USA 0- 14. Rad	ce - American I	ndien.
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the	omo	Elementery/Secondary (0-12)	College (1-4or 5+)			DAY CARE		DAY CA	ARE CEN	TER
evant	Be	17. Father's Nama (First, Middle, La			110		18. Mothar's Nam			na)	
matic	To	ST. PAUL WALK 19a. Informant's Name/Ratationship			19h Meilir	ng Address /Street	ELNORA t and Number or Rur	JOHNS		State Zin Co.	do.)
er trau		ELNORA BARNES	MOTHER				STREET,				
or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3	□Removal from		Placa of Dispo	sition (Nama of netory or other pla		Date	20c. Location		
Jury		4 □ Donation 5 □ Other (Spec	cify)	MT		CEMETERY			LANSDRO	OWN, MA	RYLAND
Important: If Item 27 is marked other than any injury or other traumatic evant, Item MOCe.		21. Signatura of Funaral Sarvice Lic	TEP A				THERS FUNE				
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	ner		Pn		or as a conseq	The state of the s	monta			1	month
Hrans	Examiner	Sequentially list conditions,	b		or as a consag		ario ma				MINITER
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of for c	iciar	Part It. Other significant conditions	contributing to de	aath but not ras	ulting in the u	ndarlying causa giv	van in Part I	23h Did	tobacco use co	ntribute to the	cause of death?
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page 2	omo							10	Yes 2 No		as 2□ No
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e fune	ation	1 Naturel 5 Pending 2 Accidant Investigati		of Injury th, Day Year)	Injury	28c. Injur Wor M 1 🗆	rk? IYas 2□No	200. Dascribe	now injury occur	160	
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	edical Co	29a. Certifiar 1 Cartifying F (Check only one)	miner: On tha be	best of my kno asis of axamina nar stated.	wledga, daath tion and/or inv	occurred at the tir restigation, In my o	me, date end placa, opinion, daeth occur	and dua to the red et tha tima,	causa(s) and ma , data end piaca,	annar es stated and dua to the	d. cause(s)
within To the	Me	29b. Signature end title of certifiar				29c. Licans	sa numbar		29d. Date signa	d (Month, Dey	, Yaar)
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Sta	ite	Kimberly Joh 31. Date filed (Month, Day, Year)	nston 132 R	201 Lagistrar's Signa	lyniver	sity Par	rkway, 1	baltin	nore, r	nd 2	1218
Registi		JAN 3 0 1998	guing	Phoens gons,-	Martora						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dey Jr. 27, 19 4c. County of Deeth Nicholas Balthazer Michel January 1998 1:35am 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) Pleasant Living Conv. Center Edgewater Anne Arundel If Under 24 Hrs. Hours Min. If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Months 10M 20 F Deys Yrs 83 157-01-5695 Aug. 12, 1914 New York Usual Residence of Decedent 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Anne Arundel Edgewater 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 510 Bay View Point Drive 21037 TISA 14. Race - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: White Specify: 3 □ Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) Electrical Engineer Navy Dept. 12 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Harriett Wiedersheim Nicholas B. Michel Sr. 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. tnforment's Name/Reletionship (Type, Print) John Michel - Son 4346 Bayside Road, Chesapeake Beach, MD 20732 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 1/31 Baltimore, MD 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Hardesty Funeral Home, P.A. 23a. Pert1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth tmmediate Ceuse (Finel disease or condition resulting in deeth) 2ho nonar dration Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Suon 24b. Were eutopsy findings evelleble prior to completion of cause 24e. Wes en eutopsy performed? of deeth? 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

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certificate Physician:

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after death. Director: Aft

To the Hospital or Att within 24 hours after of To the Funeral Direct

page 2 s hes

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that the death certificate be exe

of Vital Records, P.O. Box 68760

U O Attending Examiner

Physician/Medical

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Certification:

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7 le marked other than "natural", or items 23a or 28a-f sho treumstic event, the Medical Examinat must be notified as

nit. Peges 1 and 2 should be filed within 7 sartment of Health and Mental Hygiene. ortant: If Item 27 le marked other than "I Injury or other treumatic event, in a Max

permit. Pege Department o Important: If any Injury or

with the Maryla

death

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest

5 Pending Investigation

6 Could not be

25. Was case referred to medicel examiner? 1 Yes 2 No 27. Manner of Deeth

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work? 28e. Dete of Injury (Month, Day Year) 28b. Time of

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

Millesuille MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier

1 Naturel 2 Accident

3 Suicide

4 Homicide

13 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.
2 Medicat Examiner: On the bests of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signature and title of certifier

29c. License number

1 Yes

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

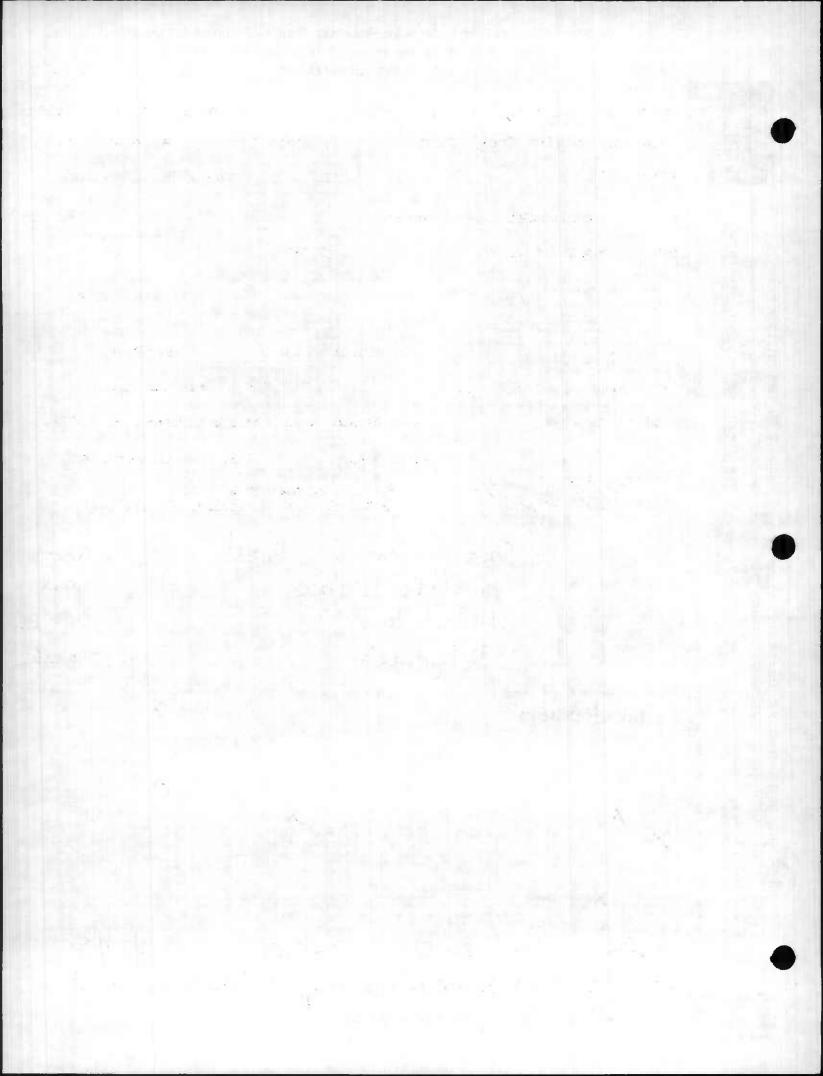
Donna Chambes HD 31. Date filed (Month, Day, Year)

JAN 30

8601 32. Registrar's Signature

Julia Davidson

State Registra



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Newton Month Yaar **Physician** 45 AM 1998 January /Medical 4c. County of Death 4a Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath/ **Examiner** Himore N.H Green If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Sociel Sacurity Number 6. Sax 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Country) **Funeral** 1 M 2 F 88 Yrs. Ga 212-16-4509 Director Usual Rasidanca of Dacedant death with the Maryland 10c. City, Town or Location 10a Stata 10b. County 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No NA Directo 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 21207 .5 3708 Dak Avenue Funeral Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status permit. Pages 1 end 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Event and any place. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🕽 📢 o Black Specify: py 3. Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry wate Elemantary/Secondary (0-12) Collega (1-4or 5+) 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be 2 aynor 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straet and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) Baltimore, Ma 3708 Wilhelmina Gwynn -Niece Place of Disposition (Nama of 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data cematary, crematory or other place 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from State MEM Harr 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funeral Sarvice Licensae Nama and Addrass of Facility 30 6 23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not entar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haert failura. List only one cause on each line. a Ho Mel Approximate Intarval Batween Onset and Daeth **Physician** Immediate Ceuse (Final disaasa or condition rasulting in daath) /Medical MI w Examiner 1540 Physician/Medical Examiner Russ attending physician and for use as the burial-transit The law requires that the death certificate be executed Saquantially list conditions, if eny, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that Initiated avants Due to (or as a consaquenca of) Division of Vital Records, P.O. Box 68760, that initiated avants resulting in death) Last Dua to (or es e consequança of): signed by the a Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown arcinoma þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformad? Completed peen s certificate has b director, pege 2 s 2 No 1 Yas 2□ No or Attending Physician: director, 25. Was casa rafarrad to madical axaminar? Be 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital: 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA After this 28a. Data of Injury (Month, Day Year) funerel 28c. Injury at Work? 27. Mannar of Death 28b. Time of 28d. Dascribe how injury occurred Certification: 5 Panding invastigation 1 De Natural 1 ☐ Yas 2 ☐ No after deeth. Director: A 2 ☐ Accidant 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Spacify) 4 Homicida 24 hours after Funeral Direction of the letely filled in b vithin 24 hours af To the Funeral DI †Scartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a, Cartifian pletely 1 (Check only 29b. Signature and title of 29c. Licansa number 29d. Data signed (Month, Day, Year)

Atensina

MS

4000

32. Registrar's Signatura

Old Court Rd

30. Name and address of person who complated cause of death (Itam 23a) (Type, Print)

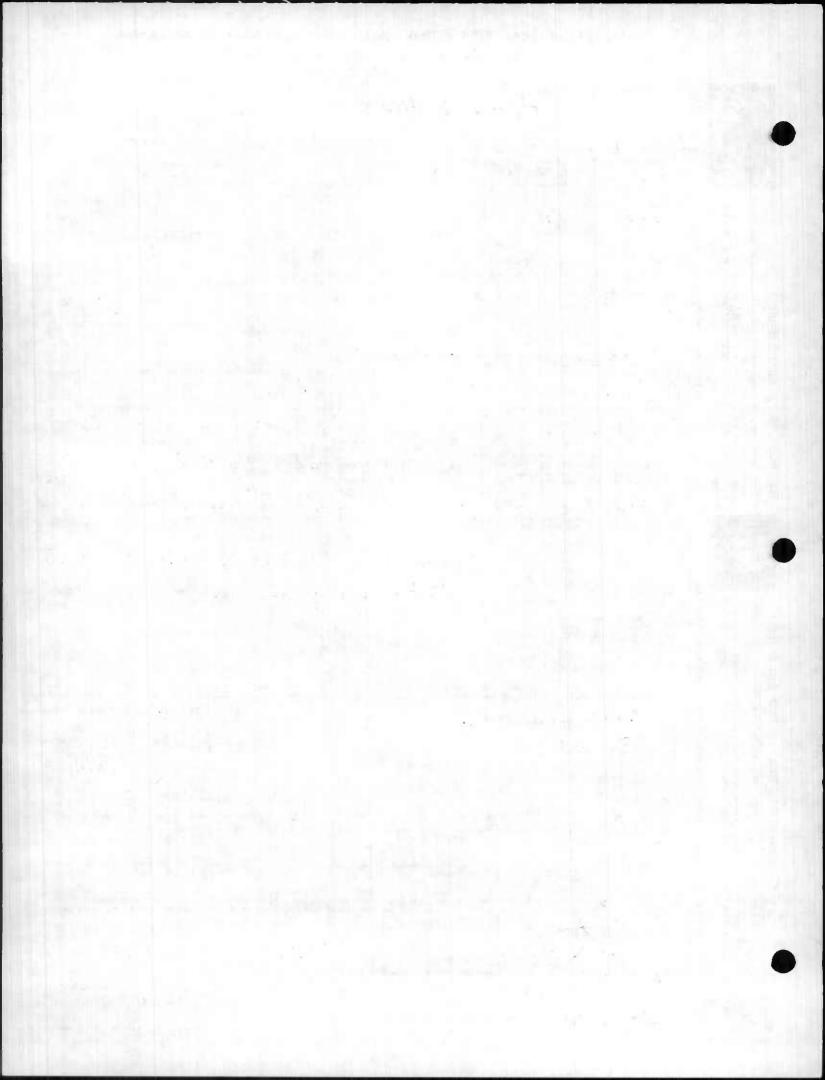
Schwartz

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State Registrar Tau

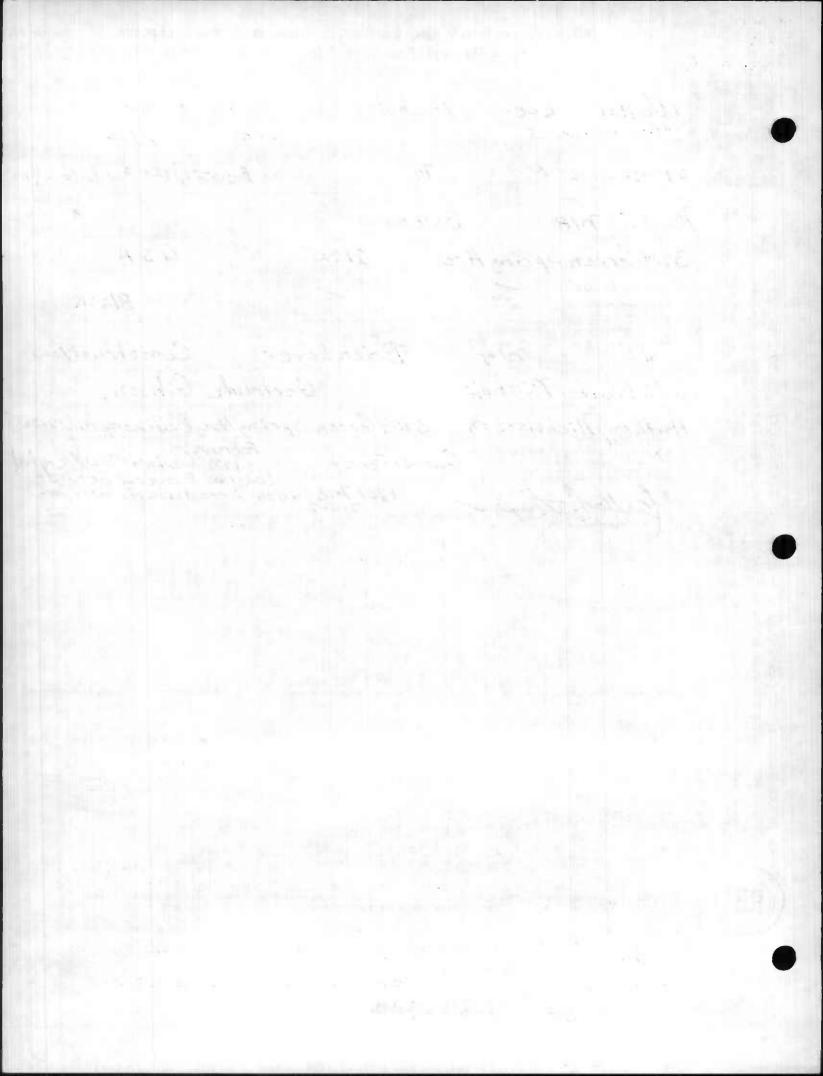
31. Date filed (Month, Day, Year)

JAN 3 0 1998



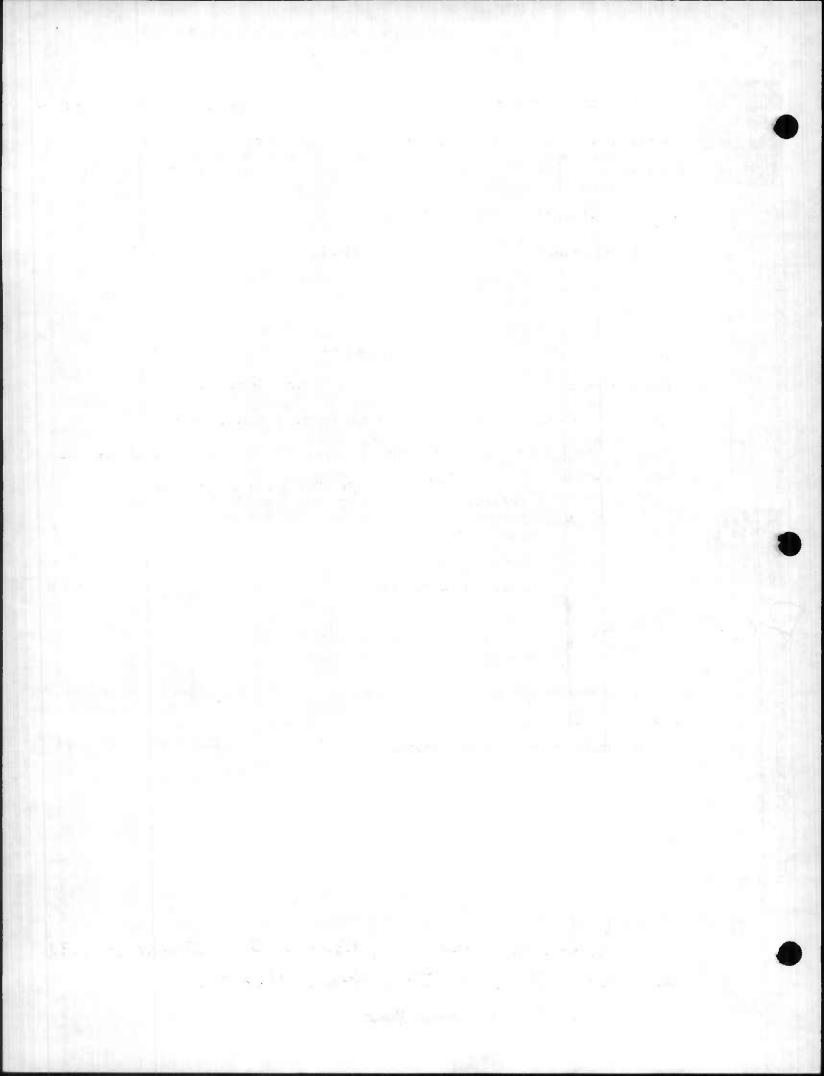
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State of Maryland / Department of Health and Menta	I Hygiene	021
Certificate of Death	Don No.	

R NICHOL	S			Certifica	ate of i	Death		Reg. No.	06.7	
Physician	1. Decedent's Name (First, Middle,	Last)	7	2.11			2. Date of Do Month	Day	Year 3. T	ime of Deeth
/Medical	Walter	Lee		richols		lb. City, Town, or	JAN.	27, 199		1:28 A
Examiner	4a Facility Name (If not institution, SINAI HOSPITAL	E.R.	Der)		1	BALTIM		th 4c. County	or Death	
Funeral	5. Social Sacurity Number 6	3. Sex 7	7. Aga (In yrs.	140.00	dar 1 Year	If Under 24 Hrs		rth	9. Birthplace (Stata or Fora
Director	242-20-7666	1 M 2□ F		74Yrs. Month	is Days	Hours Min	Rugust	24,1923	north	Caroli
ž ==	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Location					10d. Ins	side City Limi
23a or 28a-f show unt be notified at ral Director	Maryland 2/19		B	altimore					u)	Yas 20N
ritems 23s or 28s-f s sher must be notified Funeral Directo	10e. Street and Number				Zip Code			10g. Citizen of V	Vhat Country?	
23a c	3904 Green -	Spring	Ave	2	1121	5		45	A	
or items miner in	11. Marital Status	12. Was Deced	ces?	J,S. 13. Was De	cedent of H pecify Cuba	Ispanic Origin? (: in, Mexicen, Pue	Specify Yes or Note (Note 1)	0- 14. Rac Blac	e - American Inc k, White, etc.	lian,
° - >	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 Tes If Yes, Give Year or Da	9	1□ Yes	2 No	Specify:		Specify	Black	
natural",	15. Decedent's (Specify only highest			16a. Decedent's U	sual Occup	ation		16b. Kind of Bu	isiness/Industry	
. ⊆ 3 Q.	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-	4or 5+)	16a. Decedent's U (Give kind of life. DO NOT			rking	a	,	,
Co T t	12	nik	7	Bric	ck L	ayer	(F) . A (1 A A)	Con:	struci	1/02
Department of heatin and Mental ryginers important: if itsm 27 is marked other tha any Injury or other traumatic event, the once. To Be Com	17. Fathar's Nama (First, Middla, La	20:06	.1-			1	1	Maiden Suman	(8)	
marke matic	19a Informant's Name/Relationship	(Type Print)	0/3	19b. Meiling Addre	ess (Street		rude Numi	Der, City or Town,	State. Zip Code)
27 is r trau	p. 11 n.	10/5-51	12	2 caul		C	na Bre	R-Hiz	ar. m	17212
itsm ; other	20a. Method of Disposition	NOIS J		Place of Disposition (fi	Vame of		Date		City of Town, S	tate
nt: If	1 Surial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spe		tate	arriso For	08L	20/	February W. 1998	Origina	mills	Me au
Departmentimortant: any injury once.	21. Signatura of Funeral Service Li		Ge		and Addres	ss of Facility	49/955	Funer	al Ser	vide
Impol any Ir	Va. H.P.	40		1701	me	Culloh	Stre	et, But	ti more	3216
	23a. Fart1. Enter the disease, of or shook, or heart failure. List or	omplications that ca	usad tha daa	th. Do not antar tha m	oda of dyin	g, such as cardie	c or raspiratory	arrest,	Appr	oximate /al Batwaen
ysician	Took or riour lande. Call of	ny one cause on ea	ich ime.						Onse	and Death
ledical aminer	Immediate Ceuse (Final diseese or condition	. 5	motre	inhala	ation)				
	resulting in death)			or as a consequence of						
n and tal-transit Examiner		b								
sal-tran	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury		Due to (or as a consequence of	of):					
and a	mai initiated avents	С.	Due to (or as a consequence of	f);					
20 5	resulting in deeth) Lest									
for use		d								
sed for	Part II. Other significant conditions	contributing to dea	ath but not res	sulting in the underlyin	g ceuse giv	en In Part I.	23b. Dio	tobacco uae co	ntribute to the o	ause of dea
y Phy							1 (5	Yes 2□ No	3 Probably	4 Unkn
ote has been signed by the attendition to page 2 should be detached for use Completed by Physician/I							24a Wa	s an autopsy	24b. Were au	topsy finding
shou							perl	ormad?	available	prior to on of cause
page 2								Yes 28 No	of deeth	2 No
artificate sotor, pay	25. Was cese referred to medical		_			26 Place of De	ath (Check only		12165	20140
I direct	examiner? XX Yes 2 No	Hospital: 1 🗆 In	patient XX	☐ ER/Outpatient 3☐	DOA Oth	OF:		idence 6 Oth	er (Specify)	
	27. Manner of Death	28a. Date of	Injury Day Year)	28b. Time of Injury	28c. Injur			how injury occur		
atte to	1 ☐ Netural 5 ☐ Pending Investiga	tion 1-27	7-98	1048 AM		Yes 22No	House	fire		
M Director: After the forman	3 ☐ Suicide 6 ☐ Could no determin	200. Place	of Injury - At h	nome, farm, street, fact	ory, office		28f. Location City or To	(Street and Numb own, State) 3 96	per or Aural Aous	te Number,
			110	use			Baltimo	e City,	Maryla	nd 7
edical	(Check only XX Medical Ex	caminer: On the bas	sis of examina	owledge, death occurr ation and/or Investigati						euse(s)
1 N	one) 29b. Signature and title of certifier	and manne	er stated.		29c. Licans	a number		29d. Date signe	d (Month, Day,	Year)
LE 8	1 1- 10	1 11		10-		C.M.E			28, 199	
	N A A LANA	MUL	aci	7, MD	0.	C.PI.Li		OAIN.	20, 199	U
	30 Name and address of account	no completed	of donth fire	220) /Time Dules						
H	30. Name and address of person with Stephen S. R	no completed cause		m 23a) (Type, Print) 111 Penn S	treet	, Baltim	ore, Ma	ryland 2	1201	



State of Maryland / Department of Health and Mental Hygiene

		4. Providently Name (First Middle)	f 43			Certifica	te of	Death		eg. No.	U	2440	
Physician		1. Decedent's Name (First, Middle Robert J		t Sr.			#		2. Dafe of Dee Month	Day	Yeer	3. Time of De 10:40 a	
/Medicai Examiner	-	4a. Fecility Name (If not institution						4b. City, Town, o	January Location of Deeth	4c. County		10:40	auu
Examiner		Johns Hopkins			l Ce	enter		Baltimo	re	N/A	5. 2 50 111		
uneral irector		5. Sociel Security Number 186-24-7804	6. Sex 1 2 M 2 □ F	7. Aga (In yr. 68		thday) If Und Months	Deys	If Undar 24 Hr Hours Mir		1,1929	9. Birthp Cour	piaca (Stata or F	Core
A til		Usuel Residence of Decedent 10a. Stete 10b. County		10c. C	city, Tow	n or Location					1	0d. inside City L	Lim
r 28a-1 show	2		imore		Balti	imore						1 ☐ Yes 2	(2)
oner must be netfled		10e. Street and Number 947 Elton Ave	enue			10f. Z	ip Code 2122	4	1	0g. Citizen of V		ntry?	
0 1	2	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	Armad Fe	2 No	U,S.			lispanIc Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Blee	e - Americ ck, White, ,: Whi		
"natured and a second		15. Decedent (Specify only highas	's Education t grede completed)		16e.	Decedent's Us (Give kind of w	ual Occup	etion during most of width	orking	16b. Kind of B	usiness/Ind	dustry	
it, the Modical It.		Elementery/Secondary (0-12) 12th	College (1-4or 5+)		Super				Sheet	Meta	.1	
event Be	3	17. Father's Name (First, Middle, L Walter Picket							ame <i>(First, Middle, l</i> Cisenhoue		10)		
umatic		19e. Informent's Name/Reletionsh			19b	. Meiling Addre	s (Street		Rure/ Route Number		Stete, Zip	Code)	
n 27 ls her tra		Cathy Sheppar	rd/daugh		Ш,			arkway	Elton, MI				
Important: If Item 27 is marked other than "natural; any injury or other traumatic event, the Modical Exaones. To Be Completed by		20e. Method of Disposition 1 № Buriei 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (Sp	ecity)	0	cemeter	Disposition (No. 1), cremetory or Hill Ce	other ple	ry	1/28/98	20c. Location - Bal		own, Stata	
any in		21. Signeture of/Funeral Service L	icensee Low	nell	4	Conn	elly	ss of Facility Funeral Ave., I	Home of Baltimore	Essex MD 2	1221		
	1	23a. Pert1. Enter tha disease, of shock, or heart failure. List	omplications that only one ceuse on o	caused the deech line.	n. Do r	not entar fha mo	de of dyir	ng, such es cerdia	ac or respiretory err	est,		Approximete intervel Betwee Onsat end Dee	en
sician edicai		immediate Causa (Final	0	V	- 4-1						1		
miner		disease or condition resulting in deeth)			(or es a	consequence of					1	.2 month	15
dhed us-transit Examiner			Isch			diseas					1	.0 years	5
physician and s the burial-tra edical Exar		Sequentially list conditions, if eny, leading to immediate couse. Enter Underlying Ceuse (Diseese or injury thet initiated avents	c			consequence of							
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etached for use etached for use Physician/A	-	Part II. Other significent condition	ne contributing to d	eath buf not re	sulting in	the underlying	ceuse giv	ren in Pert i.	23b. Dfd to	becco uee co	ntribute to	the ceuse of d	de
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2 should 2 should pleted	-	Chronic obstru	ctive pul	lmonary	dis	ease			24a. Wes e perfor		ev	ere eutopsy find eileble prior to mplation of caus death?	
nector, page rector, page									1 □ Y	as 2 X No	1 [☐ Yes 2X No	0
		25. Wes cese referred to medicel examiner? 1 ☐ Yes ② No	Hospitai:	inpatient 2[7.50/0	tpatient 3 D	Oth	or:	eeth <i>(Check only or</i> Home 5 Reside		an /C- ani/		
Atter thi funeral funeral		27. Manner of Deeth 1 Neturei 5 Pending 2 Accident investig.	28e. Dete (Mon	of Injury th, Day Year)	28b. T	Time of njury	28c. injur Wor		28d. Describe h			<i>y</i> /	
To the Funeral Director: Alter of completely filled in by the funeral Medical Certification:		3 Suicide 6 Could n 4 Homlcide determine	ned 286. Place	e of Injury - At I	home, fa	rm, street, facto	ry, office		28f. Location (Si City or Town	reet end Numb n, State)	er or Rure	el Route Number	9F,
completely filled in Medical Cert		29a. Certifier 1 Certifying (Check only one) 2 Medical E	xaminer: On the b	best of my kn asis of exemin ner stated.	owledge etion en	, deeth occurred d/or investigetion	det the tir n, in my o	ne, dete end pleo pinion, death occ	e, end due to the courred et the time, d	euse(s) end me ate end plece,	enner es si end due to	teted. the ceuse(s)	
M M		29b. Signature and fittle of certifier	2 .					a numbar		9d. Date signe			Ī
			sibson				RES	- 00	O =	FANUAR!	7 29	, 1998	2
10	13	30. Name end eddress of person w	Tower			Type, Print)	LADL	.b- 6/	CP.TAI				
		NAME OIDZEL	(JIDY)	110	7	111/5	JAA V	INS IN	11 11 -				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Yaar Pressley Wilhemenia 9:00 am JAN 1998 26 /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Center University of Maryland Medical Baltimore N/A If Under 1 Year If Under 24 Hrs. S. Date of Birth (Month, Day, Year) 1950 5. Social Sacurity Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F 022-40-1642 47 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1. Yes 2 □ No N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Items 23a 921 North Luzerne Avenue 21205 death Funeral 12. Was Decedent Evar In U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer c. Department of Health and Mentel Hygiene.
Important: If New 27 is marked other than "natural", or item any injury ar other traumatic event, the Mentel of the Mentel 1 ☐ Never Married 🌋 Married 1 Yes 2 No If Yes, Give Yaar or Datas: 1 Yes 2 XNo Specify: þ 3 Widowed 4 Divorcad Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Admin Sec'ty State Gov't yrs 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William C. Farrell Mamie Roney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 921 North Luzerne Avenue Balto, Md. 21205 Eddie G. Pressley (Husb) 20b. Placa of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Stother (SINT Ombment Loudon Park Cem 2/02/98 Baltimore, Md. 21. Signature of Funeral Service License 22. Name and Addrass of Facility Caple Funeral Service 5502 Winner Avenue Baltimore, Md. 21215 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List any one cause on each line. Approximate Intarval Between Onset and Death Physician /Medicai Immediate Cause (Final intracranial hemorrhage disease or condition resulting in death) **Examiner** Examiner physician end the buriel-trensit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last Due to (or as a consequenca of) Box 68760. Physician/Medical Dua to (or as a consequence of): use P.O. signed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed head only page 2 s certificate Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) shis 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending To the Hospital or Attending
within 24 hours efter death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yas 2 ☐ No invastigation 6 Could not be determined 3 Suicide 28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifiar LX Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

JAN 3 0 1998

29b. Signature and title of certifian

31. Date filed (Month, Day, Year)

KATRINA

32. Registrar's Signature Jaha Davidson-Randelle

GREENE

22 S.

Rationa Surphy MD, resident

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MURPHY

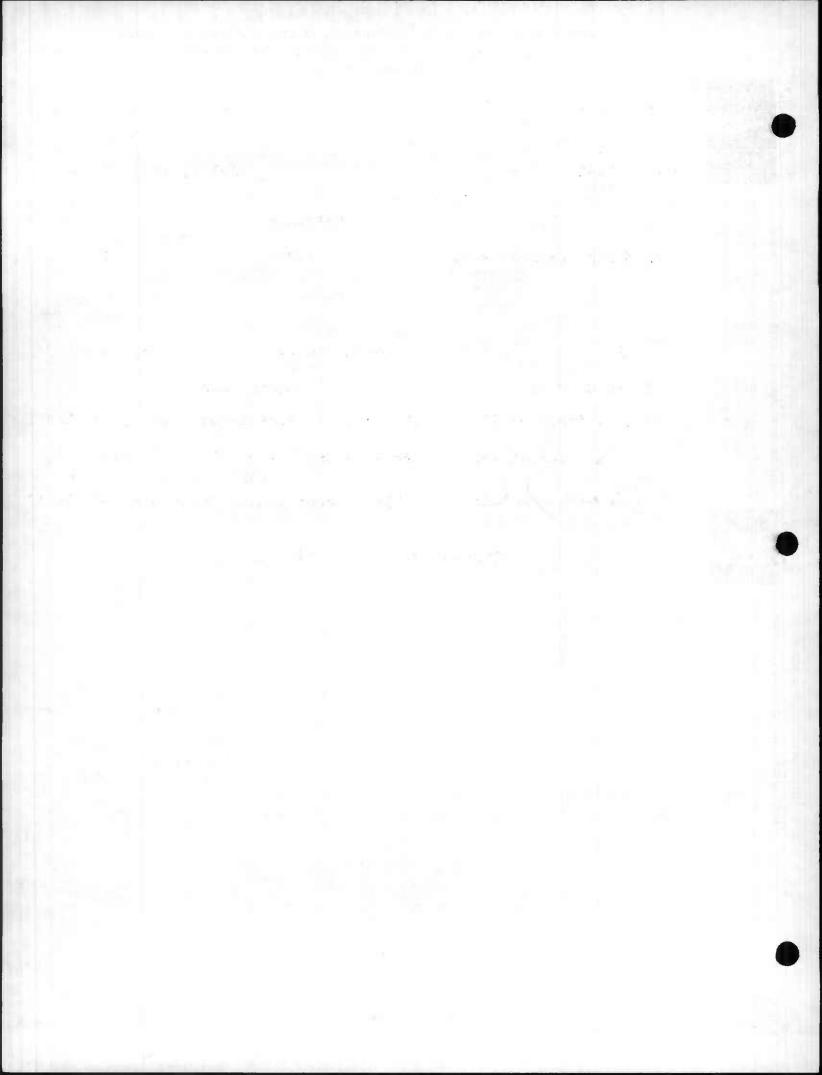
29c. License number

AU 417645

ST. BALTIMORE, MD 21201

29d. Date signed (Month, Day, Year)

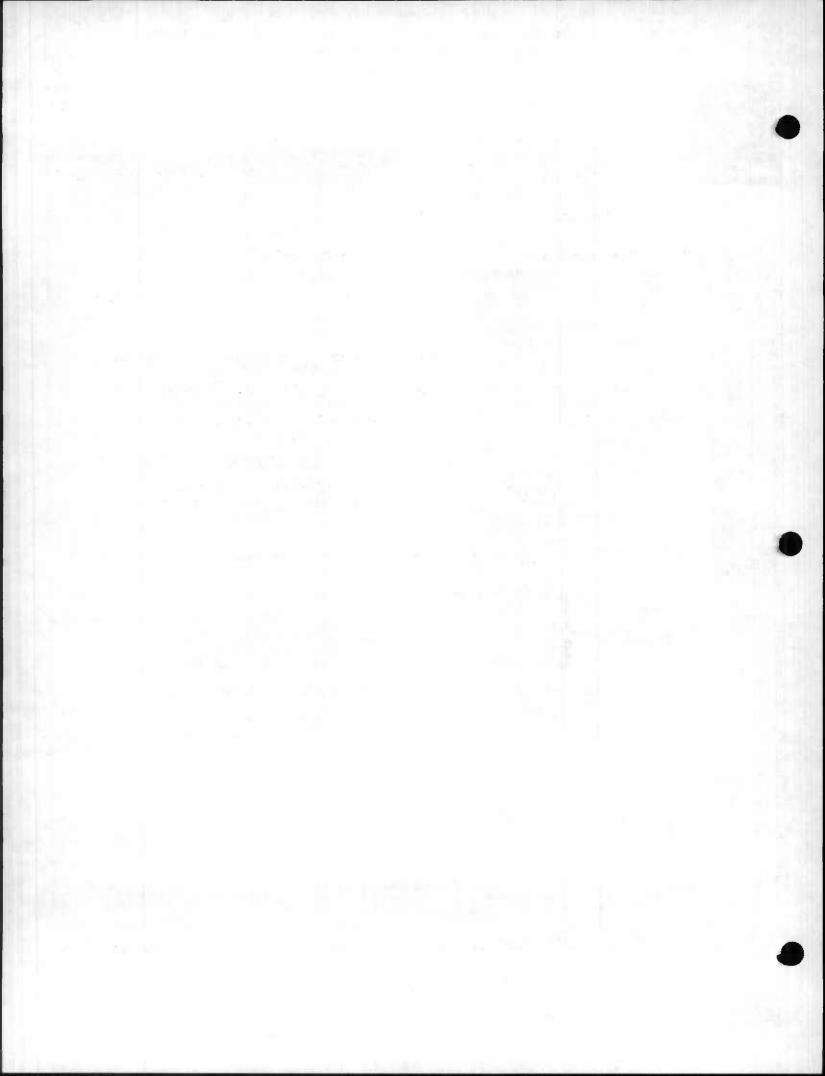
26, 1998



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician			Certific	ate of Death	1	Reg. No.	V
	Decedent's Neme (First, Middle,		10		2. Dete of De Month		3. Time of Dec
/Medical	Marion E	rnest Parker	, Jr.			28, Dey 1998	
Examiner	4e. Fecility Name (If not institution,				r Location of Deeth	4c. County of I	
		ty General H			ımbia		Howard
uneral rector	265-17-7821	. Sex 7. Age (In yrs. 17 M 2□ F 4 2	Yrs. Mont	hs Deys Hours Min		1955 No	Birthplece (State or Fo Country) Orth Caroli
A	Usuel Residence of Decedent 10e. State 10b. County	10c. Ci	ty, Town or Location				10d. toside City Li
or or			Columbia				1 □ Yes 2 🕅
be notified Director	10e. Street end Number			Zip Code		10g. Citizen of Whe	et Country?
s 23a or				21044-404	5	USA	
Item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes ②□ No If Yes, Give Year or Dates:		cedent of Hispenic Origin? (specify Cuben, Mexicen, Puess 2 No Specify:	Specify Yes or No rto Rican, etc.)		American Indien, White, etc. White
ated seed	15. Decedent's (Specify only highest	Education	16e. Decedent's U	Isuel Occupetion work done during most of w	orkina	16b. Kind of Busin	ness/Industry
it, the Medical Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	T use retired)	Urking		
2 T T T O		4	Associa		itive	Nonpr	ofit
d oth	17. Fether's Name (First, Middle, La			18. Mother's N	ame (First, Middle,	Maiden Sumeme)	
To To	Marion E	rnest Parker	, Sr.	Mary	D. Mar	ness	
E E E	19e. tnforment's Name/Reletionship			ress (Street and Number or F			
ner tr	Robin B. Parker			avan Court (
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WRC 98-0411-005 RICHARD THOMAS RAME

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

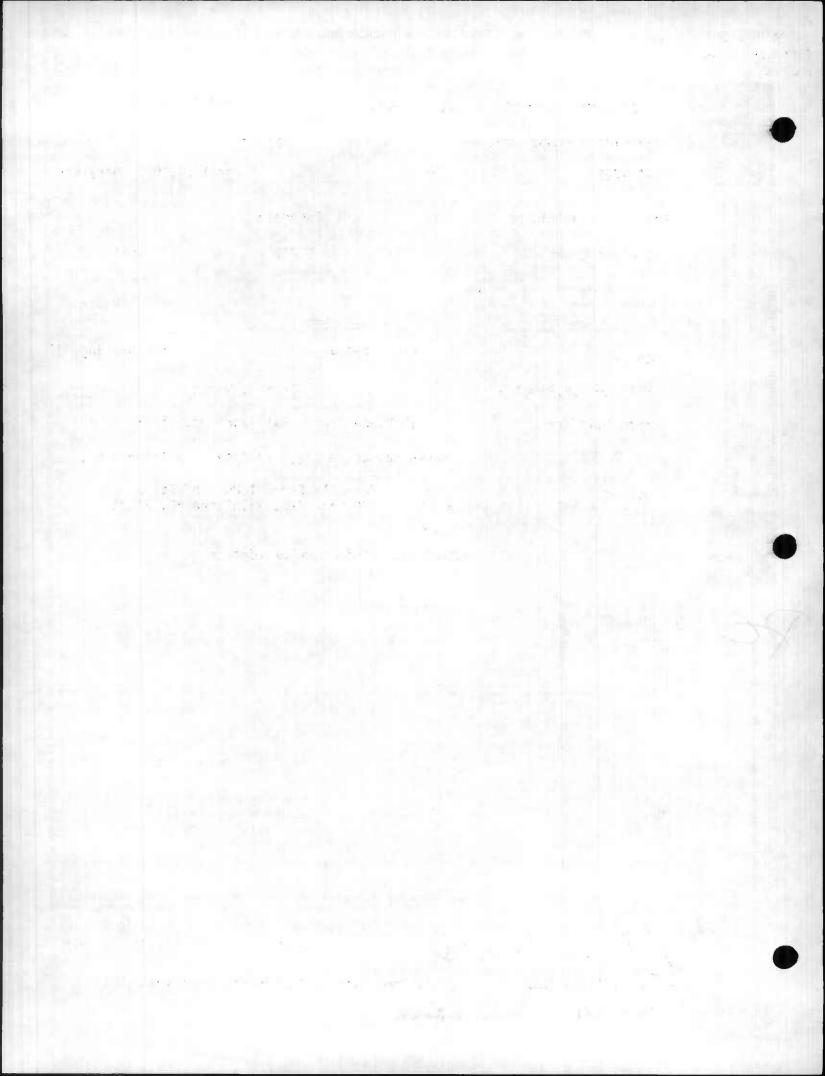
Certificate of Death	0-	white	4	10-	-46-

Υ			C	ertificate	or Death		Reg. No.	W Con	777
Physician /Medical	1. Decedent's Name (First, Middle, LI RICHARD TI		MPLEY	SR.		JANUA	ARY 28, 1	998	3. Time of Death 1:32 PM.
Examiner	4a Facility Name (If not institution, gi	RE HOSPITA				, or Location of De ESSEX	В	ALTI	MORE
Funeral Director		Sex 1√2 M 2□ F	(In yrs. last birthda 50 Yrs.	y) If Under 1 \ Months D		Min. April	Day, Year) 10,1947	9. Birthp Coun Mar	lace (State or Fore
the Maryland 28a-f show notified at	10e. State 10b. County	imore	more Rosedale						0d. Inside City Lim
h with the Mi 23a or 28a-f at be notifie al Directo	10e. Street end Number 16 Higan Court			10f. Zip Co	de 21237	THE	10g. Citizen of N	Whet Coun	ntry?
should be filed within 72 hours after death with the Maryland Manual Hygiens. marked orther than "natural", or items 23a or 28a-f show marked orther than "natural", or items 23a or 28a-f show marked orther than "natural". To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ver in U,S. 13	3. Was Decedent If Yes, specify 1□ Yes 2√		n? (Specify Yes or Puerto Rican, etc.)	No- 14. Rac Blac Specify	e - Americ ck, White, V: Whit	etc.
be filed within 72 hor tal Hygiena. d other than "natura ovent, the Moderal Be Completed	15. Decedent's E (Specify only highest gi Elementery/Secondary (0-12)	ducetion ade completed) College (1-4or 5+	-)	cedent's Usual O ve kind of work of DO NOT use n	ccupation lone during most o etired)	f working	16b. Kind of B		ing Oil
permit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiena. Important: If fear 27 is marked other than any injury or other freumatic event, the stones. To Be Compl	17. Father's Neme (First, Middle, Las William F.R.F				18. Mother's	Name (First, Midd Z S. Went	fle, Maiden Suman		
and 2 sho ealth and 8 n 27 is ma	19a. Informant's Name/Relationship Sharon M. Tedder	Type, Print)	16	Higan C	ourt Ba	or Rural Route Num I timore N	ld. 21237		
permit. Pages 1 Department of Hi Important: If Iten any injury or oft pfice.	20a. Method of Disposition 1 Burial 2 Cremation 3 [4 Donation 5 Other (Speci			position (Name rematory or othe cremator	r place)	Date 1/30/98	Baltim		
Centilians to second ding physician and measurement and measur	23a. Pan1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Arterio	sclerotic Due to (or as a cons	c Cardio equence of):	f dying, such as ce		arrest,		Approximate Interval Between Onset and Death
that the death od by the atten detached for u Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unit								
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certificate rector, pa	25. Was cese referred to medical examiner?				_	f Death (Check on	ly one)		
T T	1 Nesse 2 No 27. Manner of Death 1 Netural 5 Pending	Hospital: 1 Inpatien 28a. Date of Injury (Month, Day		1	Other: 4 Nurs Injury et Work? 1 Yes 2 No		esidence 6 Other		(y)
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After I completely filled in by the funeral Medical Certification:	2 Accident Investigation 3 Suicide 6 Could not l 4 Homicide determined	OD Dings of Injur	ry - At home, farm, (Specify)	street, factory, or	ffice	28f. Location City or	n (Street and Num Town, State)	ber or Flura	al Route Number,
within 24 hours within 24 hours to the Funeral completely filled	29e Certifier 1 Certifying P (Check day 2 Medical Exa	nysician: To the best of miner: On the basis of e and manner state	examination and/or	eth occurred at t investigation, in	he time, date end my opinion, deeth	place, and due to to occurred at the time	he cause(s) end m ie, date end place,	enner as s end due to	iteted. o the cause(s)
To the within To the comple	296. Signiflure and title of certifier	boles	no	29c. L	O.C.M.	Е.	29d. Date signe		
p	30. Laron Locke	completed cause of de			et, Balt	imore, Ma	aryland 2	1201	10-0-0-0-0

State Registrar

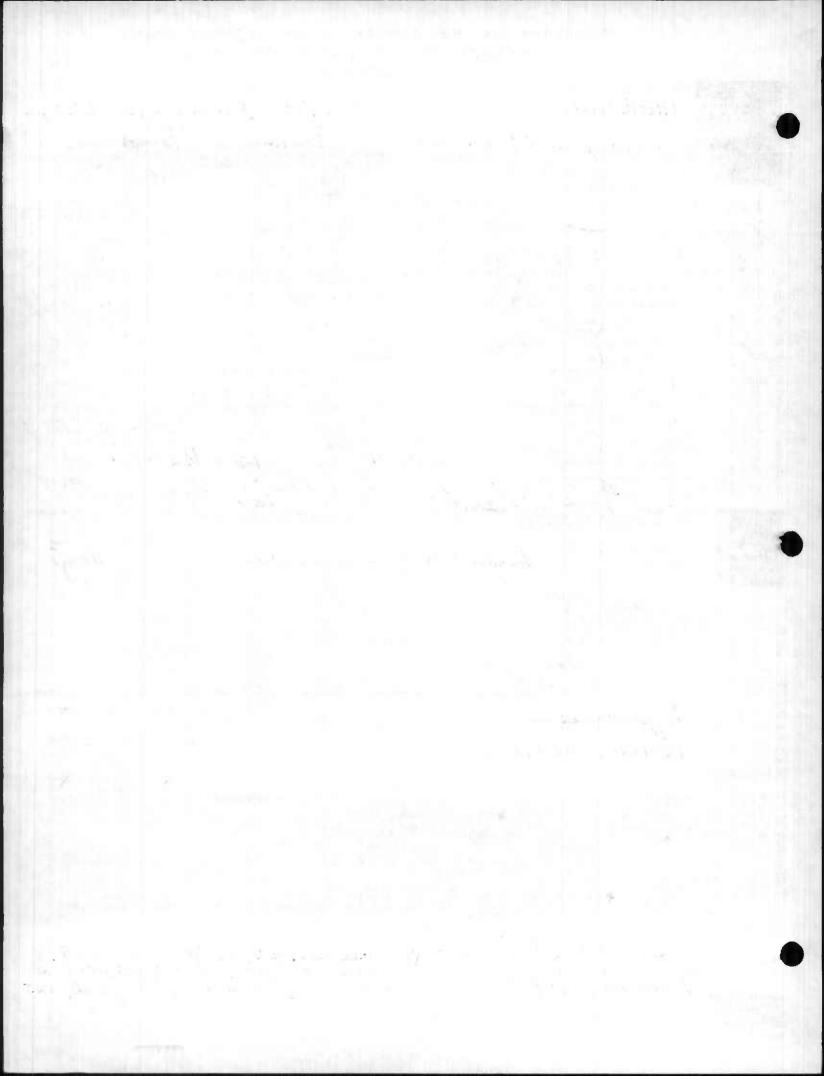
31. Date filed (Month, Day, Year)

JAN 3 0 398



State of Maryland / Department of Health and Mental Hygiene 0.0

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Funeral		5. Social Security Number 6. Se	X /. Age (in yr	rs. last birthday) If Under			Year) 9. B	irthplace (State or Fon	
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7.2 hours effer death with the Maryland "natural", or Items 23a or 28s-f show local Examinet must be notified at	0	10a. Stete 10b. County 10c. City, Town or Location Md NA Baltmore					1 Kes 2□		
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	ā	2000 Marih	attail	Auc	21215	'	Og. Onizen di Whet	C (1)	
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	un.	11. Meritel Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Never Married 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No				to Rican, etc.)	Rican, etc.) Bleck, White, etc.		
9,	by F	3 Widowed 4 Divorced	If Yes, Give / Yeer or Detes:	1 ☐ Yes	2 No Specify:		Specify: 7	2 bah	
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		20e. Method of Disposition		. Plece of Disposition (Ne	me of		20c. Location - City of	or Town, State	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month JAN erden Sutton 03044 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death ST. AGNES HOSPITAL BALTIMORE Hours Min. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar 5. Social Security Numbar 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1□ M 2XF Months Days 243-22-4260 Yrs. N.C. Usual Rasidance of Dacedant 10a. Stata 10b County 10c. City. Town or Location 10d. Insida City Limits Baltimore Ma 1 Yas 2 No NA 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? a do Avenue

12. Was Dacedant Evar in U,S.

Armed Forcas? 3509 2-1207 5 ado Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status 14 Bace - American Indian Black, White, etc. 1 Navar Married 2 Married Yas 2 No Black 1 ☐ Yas 2 ☐ No Specify: 3 Widowad 4 Divorcad Yaar or Datas 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Meade Elamentary/Secondary (0-12) College (1-4or 5+) usdotion 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Edward SIMMONS Sutton Pear 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) He 3509 E/ a Idorado Md 2207 Himore 20a. Mathod of Disposition Data 20c. Location - City of Town, Stata natary, cramatory or other place) 1 Burial 2 Cramation 3 Ramoval from State Randallstown, Mu 2-2 Men 4 Donation 5 Dothar (Specify) 21. Signatura of Funaral Sarvice Licensaa 22, Nama and Addrass of Facility F. H. Wa 23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar the mode of dylng, such as cardiac or raspiratory arrast, shock, or heart failure. List only ona causa on each line. grenue Balto, MU Approximata Intarval Between Onsat and Death Immadiata Causa (Final disaasa or condition rasulting in daath) Calles one Dua to (or as a consaquanca of) Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or Injury that initiated avants rasulting in death) Last Dua to (or as a consaquance of): Dua to (or as a consequanca of) Part II. Other algnificent conditiona contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uaa contribute to the causa of death? 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No 24b. Wara autopsy findings availabla prior to complation of causa of death? 24a. Was an autopsy 2 No 1 Yas 2 No 1 ☐ Yas 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Spacify) 1 Inpatiant 2 ER/Outpatiant 3 DOA 28b. Tima of 28d. Dascribe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygic Important: if Item 27 Is marked other I any injury or other traumatic event.

the Maryland

altimore, Maryland 21215-0020

Records, P.O. Box 68760,

Suffor Vital P

Examiner physician end s the buriel-transit Physician/Medicai ettending p use es director, page 2 should Completed Be P Certification:

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To the Hospital or within 24 hours eff To the Funeral DI completely filled in State 25. Was casa rafarred to medical

1 Yas 2 No 27. Manner of Deeth 28a. Deta of Injury (Month, Day Year) 28c. Injury et Work? 5 ☐ Panding invastigation 1 Naturel 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datamined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 ☐ Homicide

1 Cartifying Physician: To the bast of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and menner es stated.
2 Medical Examinar: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Cartifiai (Check only one 29b. Signatury d title of certifier 29c. Licansa numbar 29d. Data signad (Month, Day, Yaar)

MEDICAL RESIDENT

MD 21229

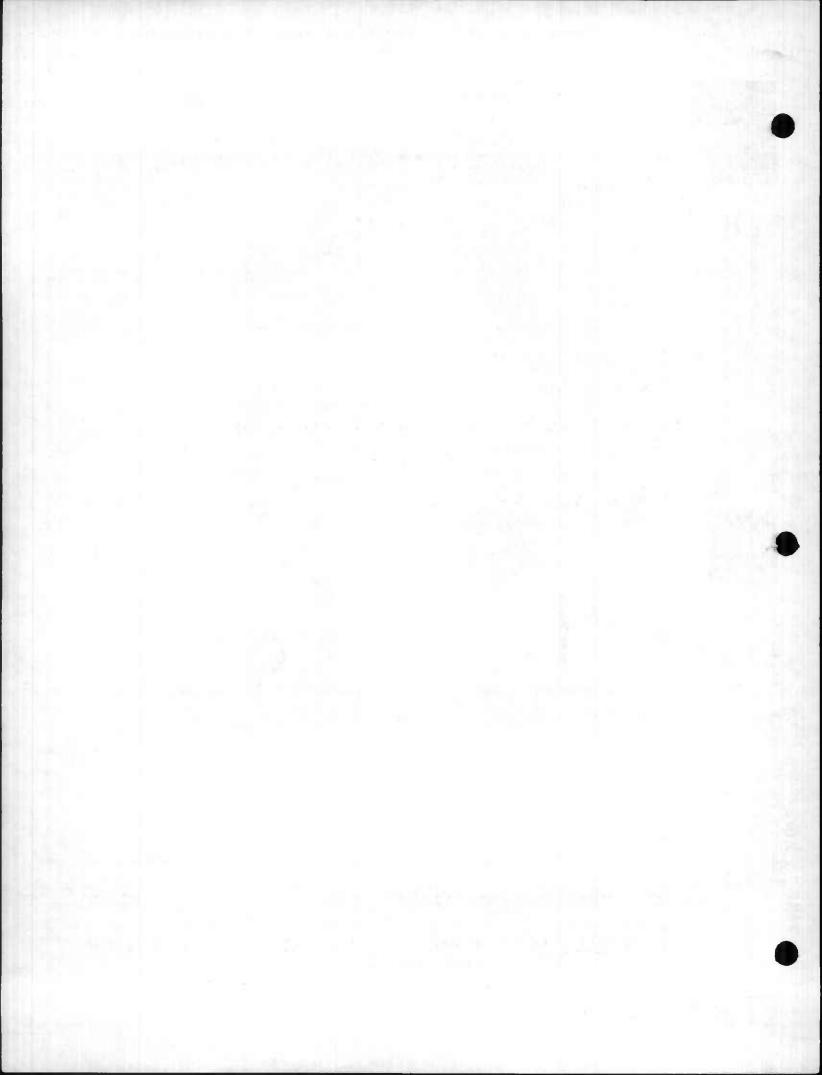
JAN. 28, 1998

30. Name and eddrass of person who complated cause of death (Itam 23e) (Typa, Print)

CHARLES C. MBONU, 900 CATON BALTO

31. Data filad (Month, Day, Yaar) JAN 3 0 1998 Registrar

32. Ragistrar's Signatura white Davidson

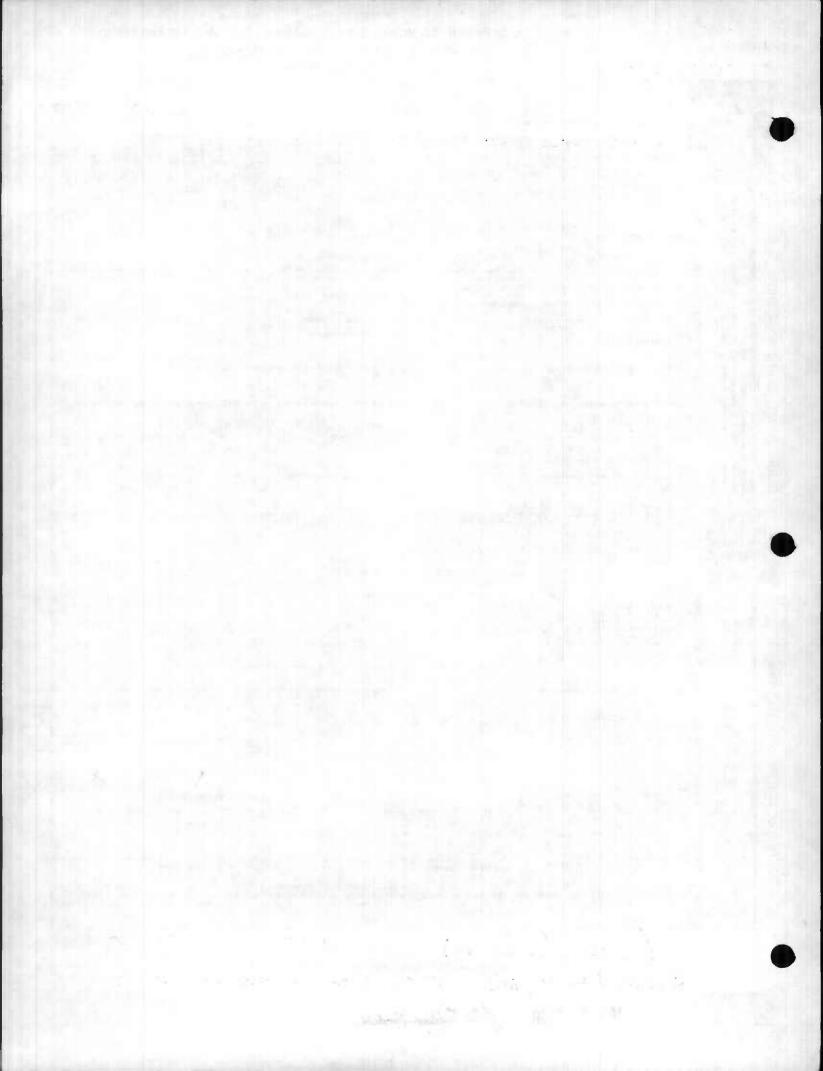


B.K.S State of Maryland / Department of Health and Mental Hygiene WILLIAM SETTLE JR. Items: 23a part I, 27 per MEO G-756 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Day Yea **Physician** William V. Settle, Jr. 2:17 PM JAN. 1998 /Medical 4b. City. Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner 141 WEST LANVALE STREET 3RD FLOOR BALTIMORE If Under 1 Year 8. Date of Birth (Month, Day, Year) 07-20-49 If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 10M 20F Yrs. 217-54-1268 48 **Director** VA. Usual Residence of Decedent the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits woule. r than "naturel", or items 23a or 28a-f eho the Medical Examiner must be notified at Md. NA Baltimore XXYes 2 No Director 10a. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code with 141 W. Lanvale Street Apt 21217 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours aftar 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 20 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: Black 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) Uneployed Never work permit. Pegas 1 and 2 should be filed v Department of Haaith end Mental Hygien Important: If Itam 27 is marked other th any Injury or other traumatic event, the DDCs. 7th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be V. Settle, Sr. William Pearl Lewis 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 19e. Informant's Neme/Relationship (Type, Pnint) William V. Settle, Sr. 1002 Witherspoon road Baltimor, e Maryland 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Voshell Mem. Gardens 01-30-98 Dundalk, Md. 22. Name end Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licensee WM.C.March FH 1101 E. North Avenue רטנימן 23a. Part1. Enter the disease, or comportations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final diseese or condition resulting in death) SEIZURE DISORDER Examiner Due to (or es e consequence of): Examiner certificate be asscuted physician end the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): SB 950 for Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? datached the character á 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Division of Vital Records, by 90 24b. Were autopsy findings evellable prior to 24a. Was en eutopsy performed? Completed completion of cause of deeth? paga 2 has 2 No 12Yes 2□ No certificata director, Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 XXYes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funaral 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After or Attending 1XXX Natural 5 Pending efter death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospitai 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hoep within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date and piece, and due to the ceuse(s) and manner stated. (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 22, 1998 O.C.M.E JAN. and address of person who completed cause of death (Item 23a) (Type, Print) Locke M 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

JAN 3 0 1998

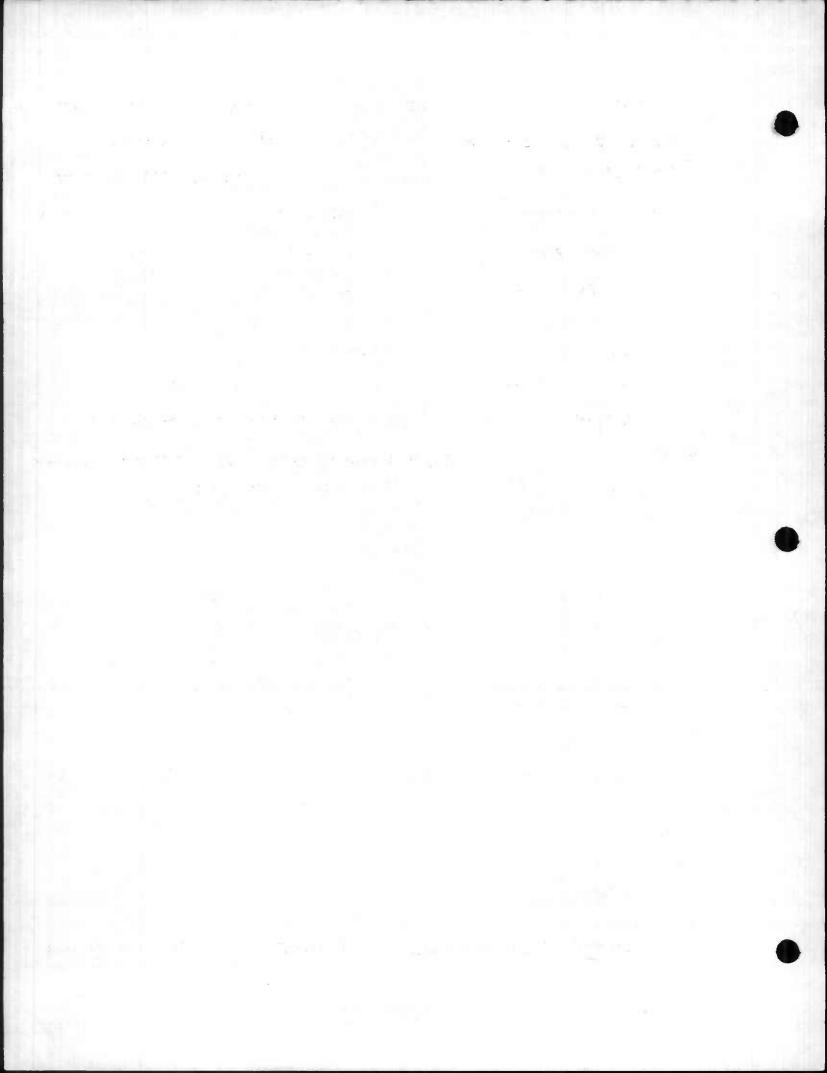
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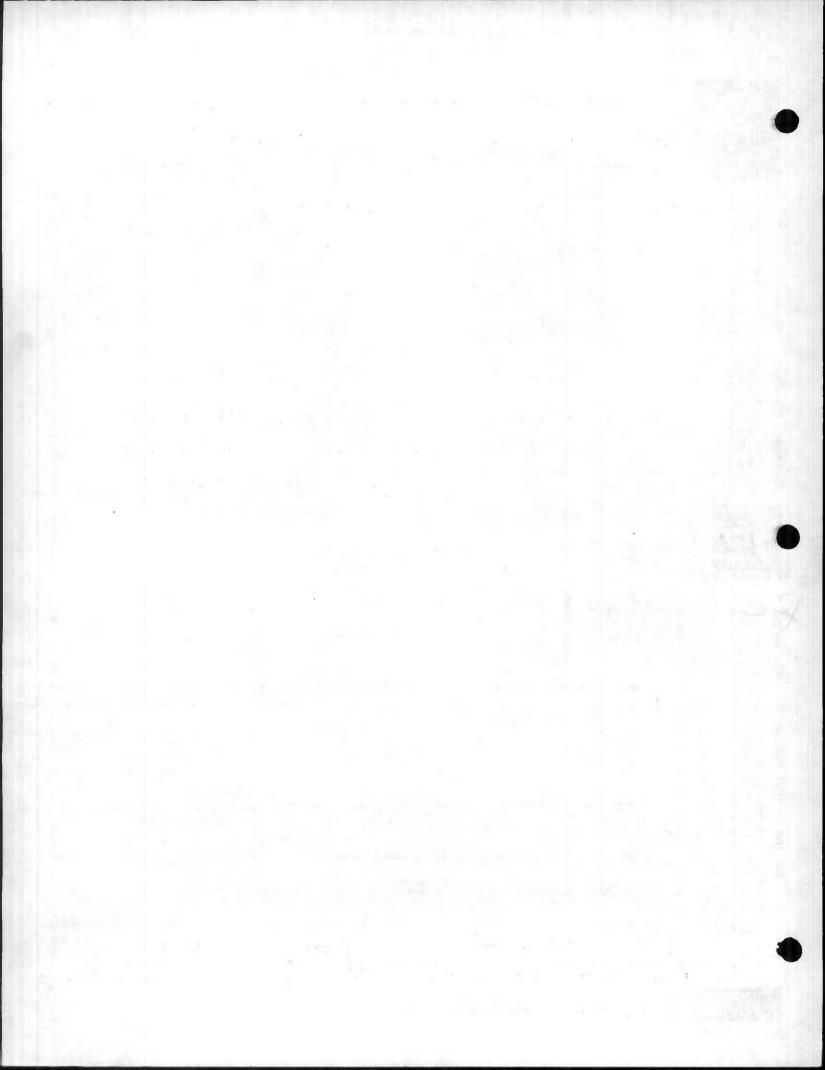
State of Maryland / Department of Health and Mental Hygiene

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	3	30. Neme end address of person wi									110
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State of Maryland / Department of Health and Mental Hygiene 9 8 0 2 4 5 4

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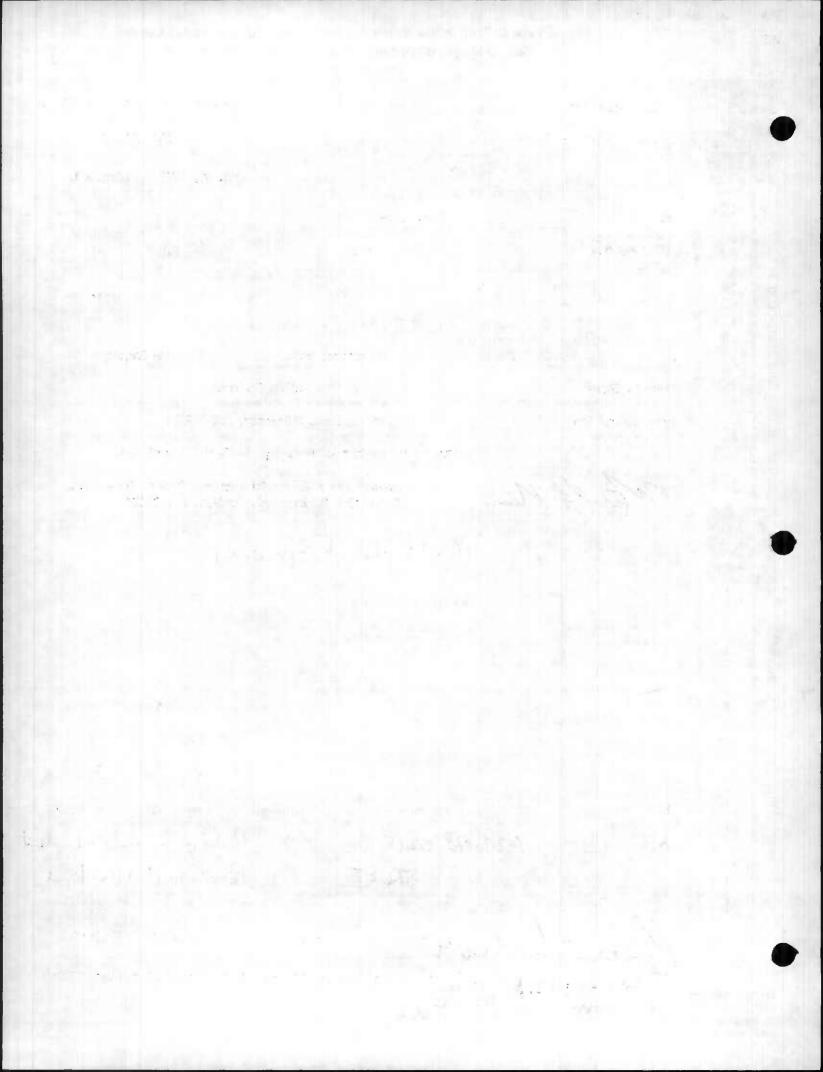
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2 Medical Examinar: On the basis of examinetion and/or invastigation, in my opinion, daeth occurred et the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Dey, Year) 30. Name and eddress of parson who completed cours of death (Item 23a) (Time Right)	To Be Completed by Physician/Me	Pr	art II. Other algorificent condition The property of the prop	d	ACUT (CORON uting to death but ital: 1 Anpatial Be. Data of Injur (Month, Dey)	Dua to (or e ACY ut not resulti nt 2 EF Yaar) 2	IS e conseque IN FER IS e conseque ART Ing In the under R/Outpatient 8b. Time of Injury	arrying ceu	DIS sa givan in 26. Othar: Unjury at Work? 1 Yes	Part I.	Of Daath (sling Home)	23b. Did 1 1 24a. Was perfo 1 1 N Chack only of a 5 Rask of Describe h	obacco usa co	24b. We evice of 1 [ra autopiliable phoplation daath?	sy findings for to of ceusa
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State of Maryland / Department of Health and Mental Hygiene Q 021, 56

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	5. Sociel Security Number	6. Se			. lest birthdey)	If Under 1 Year		8. Date of Bir (Month, De			plece (Stete o	or Fore
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Funeral Director	10e. Street end Number 180 Owad Road					10f. Zip Code 17321			10g. Citizen o		intry?	
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m	17. Fether's Neme (First, Mic	idie, Last)					18. Mother's Nan	ne (First, Middle	, Meiden Sume	eme)		
2	Clyde M. Stone						Hilda Ch					
	19a. Informent's Name/Rele		ype, Print)				et end Number or Ru			n, Stete, Zi	ip Code)	
-	Jason Stone/ So 20a. Method of Disposition	n		400		agship Roasition (Name of	ad, Baltimor	Dete Dete	1222 20c. Location	- City or T	Tourn State	
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	4 □ Donetion 5 □ Othe	er (Specify))	Dau				1-27-90	Laurel,	, PLI.		
	21. Signature of Fugeral Ser	11-	11-		Bra		on-Dabrowski				Inc.	
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edicai Examiner	Sequentially list conditions, if eny, leeding to immediate	1	b	Due to (or es e conseq	uence of):						
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an/Me		L	d									
by Physician/M	Pert II. Other significant con	ditions co	ntributing to dea	th but not re	sulting in the ur	nderlying cause g	iven in Pert I.		Yes A No		to the cause obably 4 🗆	
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	27. Manner of Deeth		28e. Dete of	Injury	28b. Time of				how injury occ		" OCH	
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	3 ☐ Suicide 6 ☐ Co	ould not be etermined	289. Place	of Injury - At I	nome, farm, str	eet, fectory, office	9	28f. Location	(Street and Nur	mber or Ru	ral Route Num	nber,
ific	4 P LOUIGIGA		Duildin	g, etc. (Spec	STRI	EET		Bord	and 12	rtfos	elan	1
Sertific		Males Ober	sician: To the b	est of my kn	owledge, death	occurred et the vestigation, in my	time, date end plece opinion, death occu	, end due to the	ceuse(s) end , date end place	menner as e, end due	steted. to the ceuse(s	e)
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edic		lical Exami	end menne	er steted.	\cap	29c. Licer O.C.	nse number M.E		29d. Date sig JANUARY		n, Dey, Year) 1998	۵)
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	HN LMAN		State of Ma	aryland / Depa	artment of rtificate of		Mental Hy	98	02457					
	Physician	Decedent's Name (First, Middle, La			amouto o	Douth	2. Date of De Month		3. Time of Death					
4	/Medical Examiner	JOHN 4e Facility Name (If not Institution, give	SOLOMON re street end number)			4b. City, Town,	JANUAR or Location of Deet	h 4c. County of I	1:36 P					
	Funeral Director	215 24 11/2	Sex 7. Ag	le (In yrs. last birthdey) 68 Yrs.	If Under 1 Yea Months Dey			N/A th ay, Year) 9.	Birthplece (State or Foreign Country)					
	Maryland a-f show	Usual Residence of Decedent 10a. State 10b. County MD. N/A		10c. City, Town or Lo	imore				10d. Inside City Limits #☐ Yes 2 ☐ No					
	items 23a or 28s-4 showing the court of the		NGTON ST.		10f. Zip Code 21223			10g. Citizen of Wha	t Country?					
020	9 9 5		12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No	Wes Decedent of If Yes, specify Cu 1 ☐ Yes #☐ N		(Specify Yes or No erto Rican, etc.)		Americen Indian, White, etc. RO AMERICAN					
Maryland 21215-0020	within 72 ane. than "nate than "nate than "nate than "nate than "nate than the second than the	15. Decedent's E (Specify only highest gr.		(Give	dent's Usuel Occ kind of work don DO NOT use reti NONE	ne during most of v	working	16b. Kind of Busin						
yland 2	should be filed and Mentel Hygia marked other umatic event, I	17. Father's Name (First, Middle, Last)	OLOMON		18. Mother's N	Name (First, Middle	, Maiden Sumame) SOLOMON						
	end 2 sho saith and 1.27 is me er traums	19a. Informent's Neme/Relationship (PAULETTE ALSTON	Type, Pnnt)		_			er, City or Town, Sta . MD. 212						
Baltimore,	Phres 1 er ment of Hea ment If Nem 2 ury or other	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of the Co		20b. Place of Disponent Completely, cred	matory or other p	place)	Date 1/23/98							
Balt	Departit Departit Importa any inj ang inj	21. Signature of Purifical Service Licer	det	20	ESTEP BF	ress of Facility ROTHERS I	FUNERAL H BALTO. M							
	Physician	23a. Part1. Enter the disease, or com shock, or heert failure. List only	plicetions that caused one cause on each li	d the deeth. Do not en	ter the mode of d	lying, such as card	diac or respiretory	errest,	Approximate intervei Between Onset and Death					
	/wedical Examiner	Immediate Cause (Final disease or condition resulting in death)	a.Hyperten	sive Arter Due to (or as a conse		otic Card	liovascul	ar Diseas	9					
,00	bhysician and the bunal-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (or as a conse	quence of):									
x 68760,	= = s	resulting in death) Last	d	Due to (or as a consec	quence of):									
, P.O. Box	ad by the deteche	Part II. Other eignificant conditions of	contributing to death b	ut not resulting in the u	nderlying cause	given in Part I.		tobacco usa contri	bute to the cause of death					
Records	aw requires is been sign 2 should be						perf	s en eutopsy ormed?	24b. Were eutopsy findings evailable prior to completion of cause of death?					
	iclan: The k certificate ha rector, page	25. Was cese referred to medical				26 Piese of (Yes 2XINo	1 ☐ Yes 2 ☒ No					
of Vital	this al di	examiner? 1 X Yes 2 No 27. Menner of Deeth	Hospital: 1 ☐ Inpatie	ry 28b. Time o		Other: 4 - Nursin	7	idence 6 Other	(Specify)					
Mision	or Attending P flor death. In by the tuner in by the tuner.	1 XNatural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	e 28e. Place of Inj	ury - At home, farm, st c. (Specify)	M 1	☐ Yes 2 ☐ No	28f. Location City or To	(Street and Number wn, State)	or Rural Route Number,					

State Registrar

29a. Certifier (Check only one)

29b. Signature end title of certifier

30. Name and eddress of person who completed cause of data (Item 23a) (Type, Print)

Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Yeer)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated.

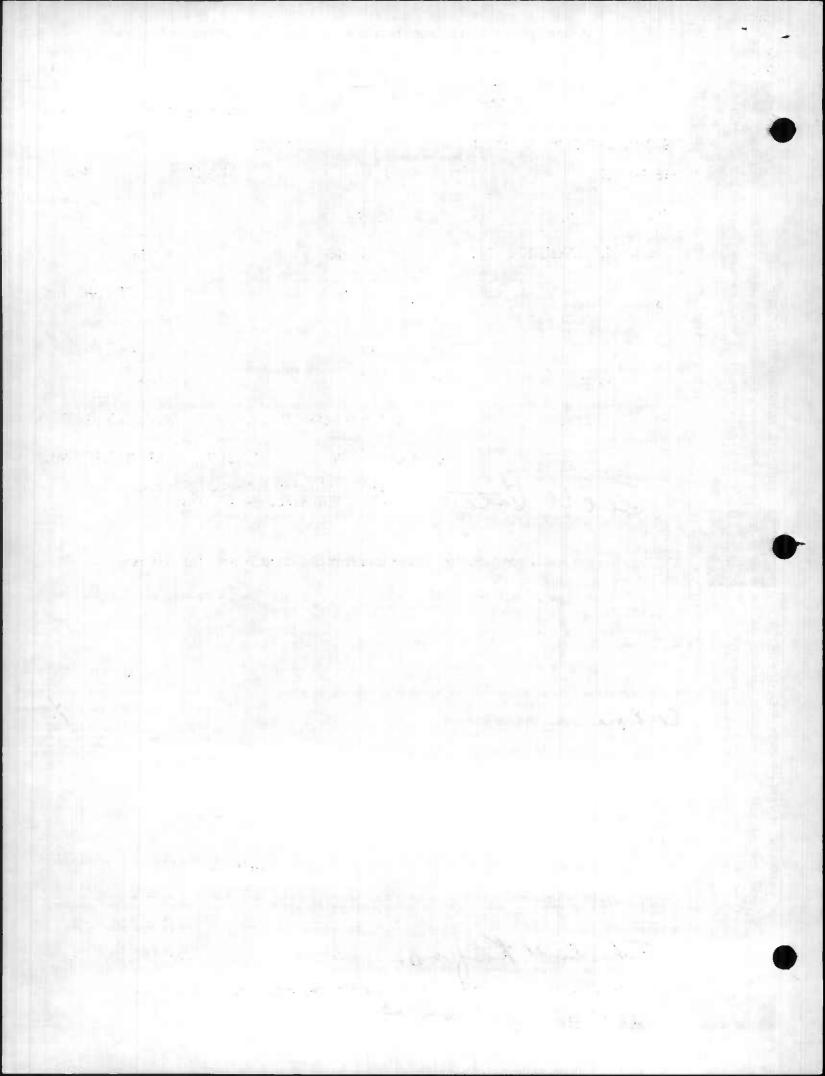
2 Medicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

OCME

29d. Date signed (Month, Dey, Year)

JANUARY 19, 1998

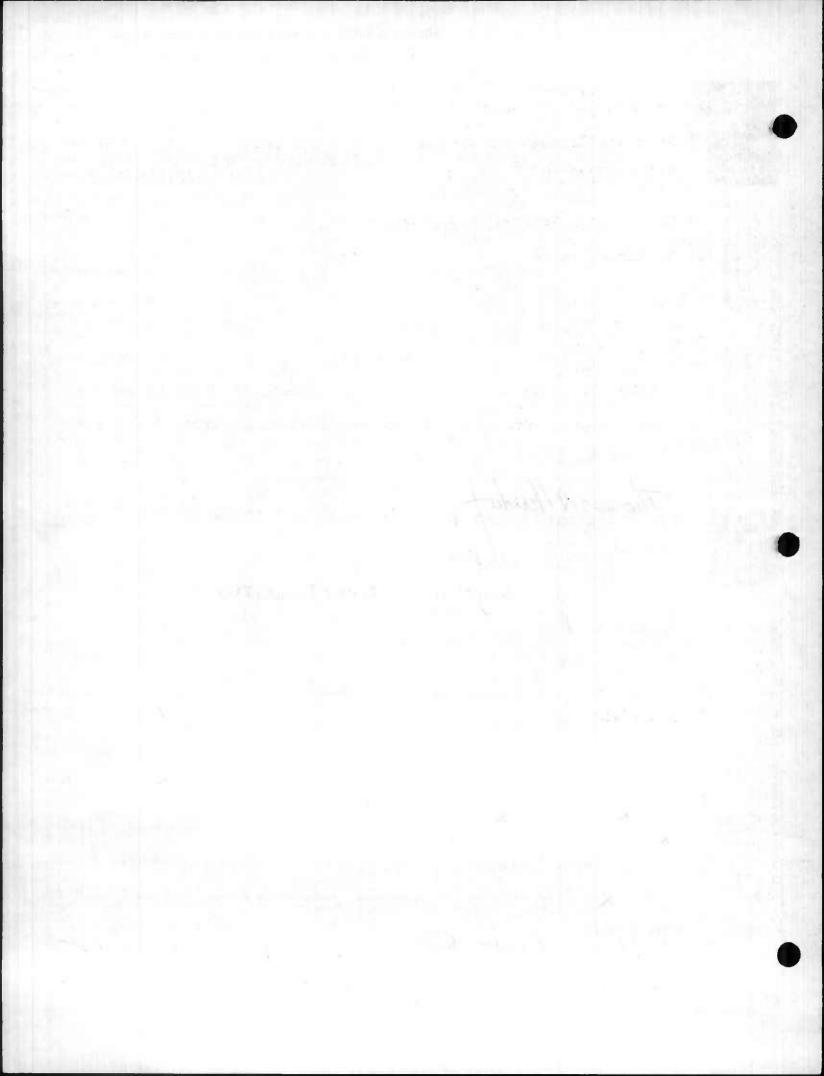


		1. Decedent's Name (Firs	Middle I	ast)				te of		2. Dete of I	Reg. No.		- J 6 m	2 Time of Death
Physicia		WILLIAM	EDWA			STREET	II			JANUA	Day	. 19	/ear	3. Time of Deeth
/Medic Examin		4e. Facility Name (If not in				SIKEEI	11		4b. City. Town.	or Location of De		ounty of		7:10 P.N
Examili	let	721 EAST 2			(HOM	E)			BALTIM		40. (Deali	
Funeral		5. Social Security Number	6.	Sex		s. last birthdey		er 1 Year	If Under 24 H	rs. 8. Date of I	Birth .	N/A	9. Birthpled	e (State or Foreig
Director		216-34-6585 Usuai Residence of Dece		1 X IM 2□ F	59	Yrs.	Months	Days	Hours M	in. B. Date of I	17,19		Country	MORE,MD.
sdat		10a. State 10b.	County		10c. C	City, Town or L	Location						10d.	. Inside City Limit
28a-f sho	to	MARYLAND				BALTIM	ORE							1 X Yes 2 □ N
or 28a-f	Director	10e. Street and Number					10f. Z	ip Code			10g. Citiz	en ot Wh	et Country	?
23	al	721 EAST 2	O STF	REET.			2	1218			USA			
natural', or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2. 3 Widowed 4 D		12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da	rces? 2 XNo e	U,S. 13			ispenic Origin? nn, Mexicen, Pu Specify:	(Specify Yes or lefto Ricen, etc.)		Black,	American White, etc	
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and Mental Is marked o aumatic ev	10		STREE						LUCIL		ATTHEW			
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0		1 X Buriai 2 Cren 4 Donetion 5 DO	ation 3 [State	COMOTON, CR	IDGE (other place	ERY	1/26/98	BALT	IMOR	E, MA	
Department Important: I sny Injury once.		21. Signeture of Funeral S LLQVD M. 23a. Part1. Enter the dike shock, or heert taken	OFST	EP Ost	ause) the dea	13	300 E	UTAW	PLACE,	NERAL HO BALTIMO iac or respiratory	RE. MA	A. ARYLA	A	pproximate
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xaminer	liner	Immediate Cause (Finel disease or condition resulting in deeth)			Due to	OIAL (or as a conse	INF	ARC):					10	minus
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State of Maryland / Department of Health and Mental Hygiene

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/Medical	Celeste	Soper			January	28,	1998 5:3	5 pm
xaminer	4a. Fecility Neme (If not institution, g			4b. City, Town, or Lo	ocation of Death	4c. County	of Deeth	
	Anne Arundel			Annapol	is	Anne	Arundel	
neral ector	212-40-7030	Sex 1□ M 2 F 7. Age (In yrs. 81	last birthday) If Under 1 Yes Months Dey		8. Date of Birth (Month, Dey,) March3	(eer) , 1916	9. Birthplace (State Country) Marylan	or Foreign
E	Usuel Residence of Decedent 10a. State 10b. County	10c. City	y. Town or Location				10d. inside (City Limite
0		esterate and the second						s 2 No
ect of	10e. Street and Number	ar under An	napolis		100	Citie414		
	29 Sands Aver				100	g. Citizen of W	met Country?	
era	11. Maritel Stetus	12. Wes Decedent Ever in U.	2140		asita Van an Na	USA	a - American Indian,	
Examiner must be notified at by Funeral Director		Armed Forces?	If Yes, specify Co	f Hispenic Origin? (Spuban, Mexican, Puerto o Specify:	Rican, etc.)		k, White, etc.	
ted be	15. Decedent's	Education	16a. Decedent's Usuel Occ	upation	. 16	Bb. Kind of Bu	siness/Industry	
or other traumatic event, the Manical Exa	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+)	Iffe. DO NOT use reti	ne during most of work red)	ing	Own I	Home	
Be C	17. Fether's Neme (First, Middle, La	st)		18. Mother's Name	e (First, Middle, Me			
To	William A. Jo	hnson		Gertr	ude Fit:	zsimmo	ons	
5	19e. Informent's Neme/Relationship	(Type, Print)	19b. Meiling Address (Stre					
4	Ronald Soper	- Son	5 Manorbro	ok Road,	Monkton	, MD	21111	
any injury or other ti	20e. Method of Disposition	20b. P	lece of Disposition (Name of emetery, cremetory or other p		T	*	City or Town, Stete	
2	1 ☐ Buriel 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spec	Puento Aet Itom State	tro Cremato		· R:	altimo	ore, MD	
any injury	21. Signature of Funeral Service Lic	ensee	22 Name and Add	Irace of Encility				
any ir	23a. Pert1. Enfer the disease, or co shock, or heert failure. List on	Ha. 1.1	Hardest	v Funera	l Home.	P. A.		
	Moman	HOUSE	12 Ridg	ely Ave.	Annapo	olis,	MD 214 Approxime	01
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be detached for us	Pert II. Other significant conditions COPD	contributing to death but not resu	uting in the underlying cause (given in Pert I.	1 🗆 Yes		tribute to the cause 3 Probably 4	
2 should pieted					24e. Wes en performe	eutopsy ed?	24b. Were eutopsy evelleble prior completion of of deeth?	to
ector, page 2					1 ☐ Yes	2 No	1 ☐ Yes 2 ☐] No
Be C	25. Wes case referred to medical			26. Plece of Deet	n (Check only one)	74.		
OB	exeminer?	Hospitel:	ER/Outpetient 3□ DOA	Whor.	me 5 Residence	ca 6 □Othe	r (Specify)	
	27. Menner of Deeth	28a. Dete of Injury	28b. Time of 28c. Inj		28d. Describe how			
1 0	1 Naturel 5 Pending 2 Accident investigati	(Month, Dey Yeer)		ork? ☐ Yes 2 ☐ No				
ed to be contacted to be	3 Suicide 6 Could not determine	be 28e. Plece of Injury - At ho building, etc. (Specify	me, farm, street, factory, offic	a	281. Location (Stre City or Town,		er or Rural Route Nut	n <i>ber</i> ,
completely filled	29e. Certifier (Check only one) Certifying F	hysicien: To the best of my know miner: On the basis of examinet and menner steted.	vledge, deeth occurred et the ton end/or investigation, In my	time, date end pleca, opinion, deeth occurr	end due to the ceu ed et the time, dete	se(s) end mer e end pleca, a	nner es steted. nd due to the cause(s)
Ме	29b. Signeture end title of certifier		29c. Lice	nse number	290	I. Date signed	(Month, Day, Year)	
	1 Slaine	Chata Me	+ NU	5297		1- 2	8-98	•
	30. Name end eddress of person who Elaine an 31. Date filed (Month Pay Year)	completed cause of death //tem	23e) (Type Print)	1		1 4	0 10	
	So. Ivalie and eduress of person who	a Training course of deeth (Item	1000 (1900, Print)	of Modic	Al Con	ter 1	Annap. M	10
Chaha	31. Date filed (Month, Day, Year)	32. Registrer's Signat	ure I (Mande	1 1/1001	.1(1)	101-11	1. 4.14 1 1	
State		San Transfer of Barrior						

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yee **Physician** HARRY 20, 1998 SPIWAK January 9:00 A.M. /Medical 4e. Fecility Name (If not institution, giva straat and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 1801 East Jefferson Street, Apt. 636 Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 15 M 2□ F Months Yrs Director 578-12-7473 Nov. 27, 1907 Poland Usual Residence of Deceden the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1€ Yes 2□No Montgomery Maryland Rockville Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 1801 East Jefferson Street, Apt. 636 20852 death U.S.A. Funeral 12. Wes Decedent Evar In U,S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - Americen Indien, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 25 No Specify: à 3℃Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 72 th and Mental Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 Years Printing Specialist U.S. Government 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumema) Be Abraham Spiwak Rachel Hoffspeigel 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 Department of Health at Important: If Item 27 Is any Injury or other traus Stanley M. Spiwak 3100 N.E. 47th Court, Ft. Lauderdale, Florida 33308 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 1/21/1998 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) Mount Lebanon Cemetery Adelphi, Maryalnd 21. Signature of Funeral Service I Icensee 22. Name and Address of Fecility Donald STEIN HEBREW MÉMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, NW, WASHINGTON, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immadiata Cause (Final disease or condition resulting in deeth) ARTERIOSCLEROTIC HEART DISEASE Examiner 5 YRS Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Ceuse (Disease or injury Dua to (or as a consequence of): Box 68760. certificate be Physician/Medical thet initiated events resulting in deeth) Last Due to (or es a consequança of) 88 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? the signed by ti 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ESSENTIAL HYPERTENSION Records. by 24b. Were eutopsy findings evaileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy parformed? Completed peen BENIGN PROSTATIC HYPERTROPHY page 2 HYPOTHYROIDISM certificate 1 ☐ Yes 2 X No 1 ☐ Yas 2 ☐ No Division of Vital 25. Wes cese referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospitel: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Tyes 2€3tNo 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? After or Attending 5 Pending investigation (X)Netural death. 1 ☐ Yes 2 ☐ No after death Director: A d in by the f 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, streat, fectory, office building, etc. (Specify) 4 | Homicide Mospital of 24 hours a Funeral D *** Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) within 2 the 29b. Signeture end 29c. License number 29d. Date signed (Month, Dey, Year) 0 D09946 January 20, 1998 H' 30. Neme end address of person who completed ceuse of deeth (Item 23e) (Type, Print)

Henry Roth, M.D., 1801 East Jefferson Street, Rockville, Maryland 20852

whia Davidson Randall

32. Registrar's Signeture

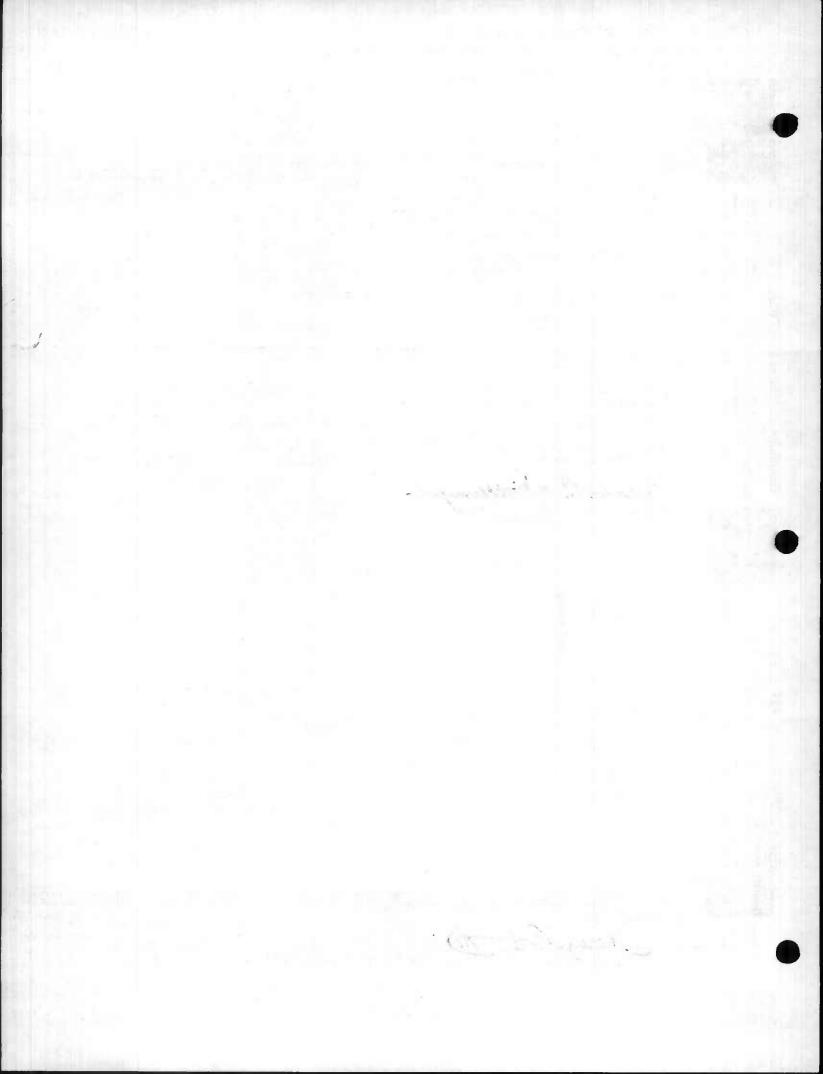
DHMH 16 Rev 6/95

Registrar

31. Dete filed (Month, Day, Year)

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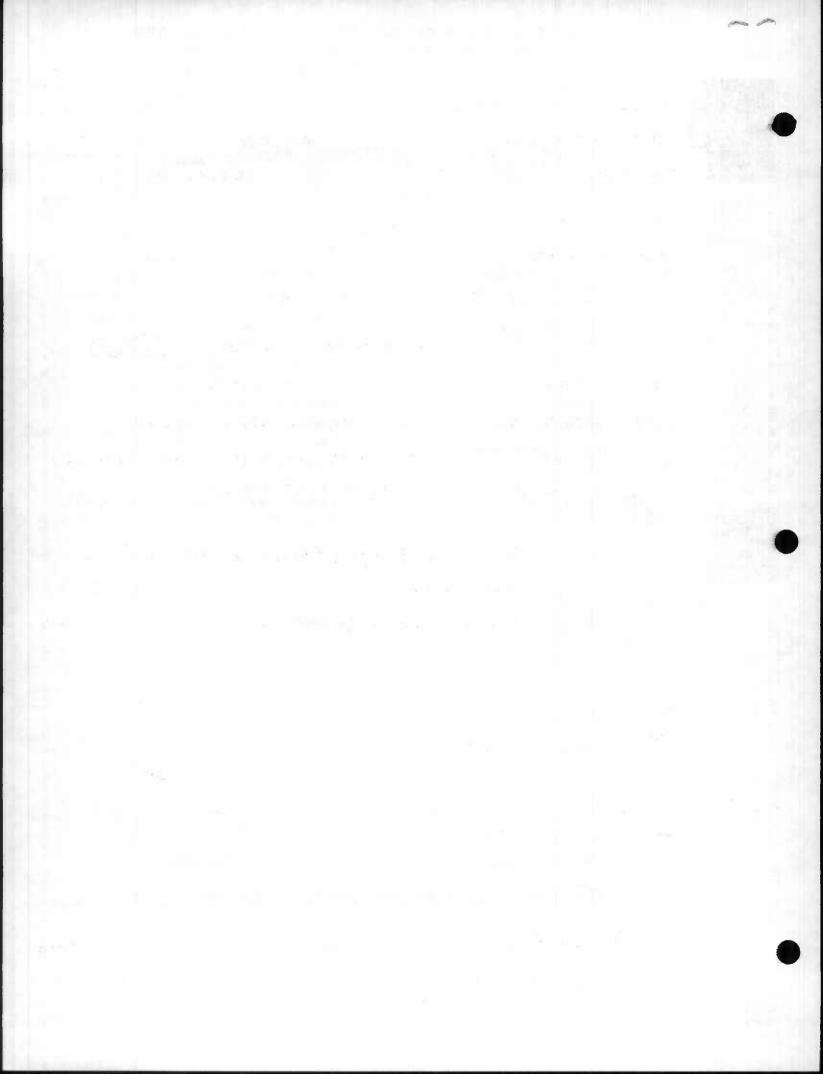


State of Maryland / Department of Health and Mental Hygiene

					Cei	rtificate d	of Death		R	eg. No.	Ud	461
		1. Dacadant's Nama (First, Middla, Las	st)						ata of Daat	th	Vees	3. Tima of Death
Physicia /Medic		William Pau	ıl Shai	nahan					_	27. 19	Yaar 9.8	6:30pm
Examin		4a. Facility Nama (If not institution, give	a street and number))			4b. City, Tow	n, or Location		4c. County		0.500111
		4144 Wilkens	Ave.				Balti	more		Ва	ltim	ore
Funeral		5. Social Sacurity Number 6. S		ga (In yrs. las	st birthday)	If Undar 1 Ya	ar If Undar 2	4 Hrs. 8 Da	ta of Birth		9. Births	olaca (Stata or Forai
Director		212-05-2610 Usual Rasidance of Dacedant	ØM 2□ F	83	Yrs.	Months Da	ys Hours		c.30	1914	MD.	ntry)
with the Meryland a or 28a-f ehow be notified at		10a. Stata 10b. County		10c. City,	Town or Lo	ocation					1	0d. Insida City Limit
r 28a-f ehow	tor	MD. Baltimore	9	Ral	timor	~						1 □ Yas 2 □ N
or 28	Director	10e. Straat and Number		100		10f. Zip Cod	la		1	0g. Citizan of V	Vhat Cour	ntry?
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e ta	ШО	8	Conage (1 401)	04)	assis	stant ch	nief of	sanita	tion			on Dept.
I S S	Bec	17. Fathar's Nama (First, Middla, Last)					18. Mothar	's Name (First	, Middla, I	Maidan Sumam	a)	-
2 D .	ToE	Albert Shanal	nan				Mary	Anne	Somme	ers		
th end Mer 7 is marke traumatic		19a. Informant's Nama/Ralationship (7	ype, Print)		19b. Mailir	ng Address (Str	eet end Number	or Rural Rou	a Number	, City or Town,	Stata, Zip	Code)
20 F		Mary M. Shanahar	n, wife		4144	Wilkens	Ave.,	Baltim	ore.	Md. 21	229	
He		20a. Mathod of Disposition		20b. Plac	ce of Dispo	sition (Nama o		Dat		20c. Location -		own, Stata
0 = 5		1 ☐XBurial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				natory or other	etery 1/	30/98		Baltin	noro	MD
Depertment: Important: any injury once.		21. Signature of Funaral Sarvice Licen		Doud			drass of Facility			Daici	iore,	· LID.
mpoi any ir		21. Signature of Fundral Salvice Licent					uneral		Inc			
		23a. Part1. Enter the disease, or comp	Semm	er	1	630 Edn	nondson	Ave.,	Cator	sville	, Md.	21228
hysician		shock, or haart failure. List only o				_	_					Approximata Intarval Between Onsat and Death
Medical xaminer		Immediata Causa (Final disaase or condition rasulting in death)	. Enter	70 COC	cal	Sepsis	(Vanc	comyc	in fe	sistan	1)	3 WKS
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her th		27. Menner of Death Natural 5 □ Pending	28a. Data of Inju (Month, De	Iry 28	8b. Tima of	28c. l	njury at Work?	28d. D	ascribe ho	ow Injury occur	ed	
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Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 27,1⁹⁹⁸ Month **Physician** Joseph Tracy, Sr. January 6:30pm /Medical 4a. Facility Nama (If not institution, give straat and number) 4b. City, Town, or Location of Daath 4c. County of Deeth Examiner Mariner of Overlea Baltimore 5. Sociel Sacurity Number If Undar 1 Year If Under 24 Hrs. 7. Aga (In yrs. lest birthday) Birthplece (Stete or Foraign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** 1XX 2 F Deys 53 Yrs. Director 212-44-5147 Sept. 28, 1944 Usual Residence of Decedent deeth with the Meryland 10a. Stete 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD n/a **Baltimore** 1 Xes 2 □ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? ŏ 5813 Moores Run Ct. 21206 23a USA Funerai itema 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Bleck, White, atc. 11 Marital Status filed within 72 hours efter 1 Never Married 2 Married 1 Nos 2 No If Yes, Give 65 Yaar or Dates: 21215-0020 ò 1 ☐ Yes XXNo Specify: by Specify: Black 3 Widowed 4 Worced naturei Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grede completed) other than Elementery/Secondary (0-12) College (1-4or 5+) Bus Driver MTA 12th traumatic event. Baltimore, Maryland 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Surnama) Be Pages 1 and 2 should be 1 nent of Health end Mentei I int: if item 27 is marked of Luther Tracy Hattie Cox 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Janet Tracy/sister 5813 Moores Run Ct. Balto., MD other 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 XXXvial 2 ☐ Cremetion 3 ☐ Removel from Stata ŏ permit. Page Department of important: if eny injury or 4 ☐ Donetion 5 ☐ Other (Specify) Garrison Forest Va 2/02 Owings Mills, MD of Funerel Service Licensee 22. Name end Address of Fecility James A. Morton & Sons Funeral Home 13 1701 Laurens St. Balto., MD tar the disaasa, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiretory errest, the heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medicai Immediate Cause (Final Ischenic disaase or condition resulting in deeth) heart objects Examiner Due to (or as a consequence of): Examiner The lew requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseesa or injury that initiated events resulting in death) Lest and Due to (or es a consequence of): Box 68760. ettending physicien Physician/Medical the Due to (or es a consequence of) USB BS ed by the e Pert II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. à 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed? hes this certificate 1 Yes 2 No 1∏Yes 2∏No ai or Attending Physician: The safter deeth.

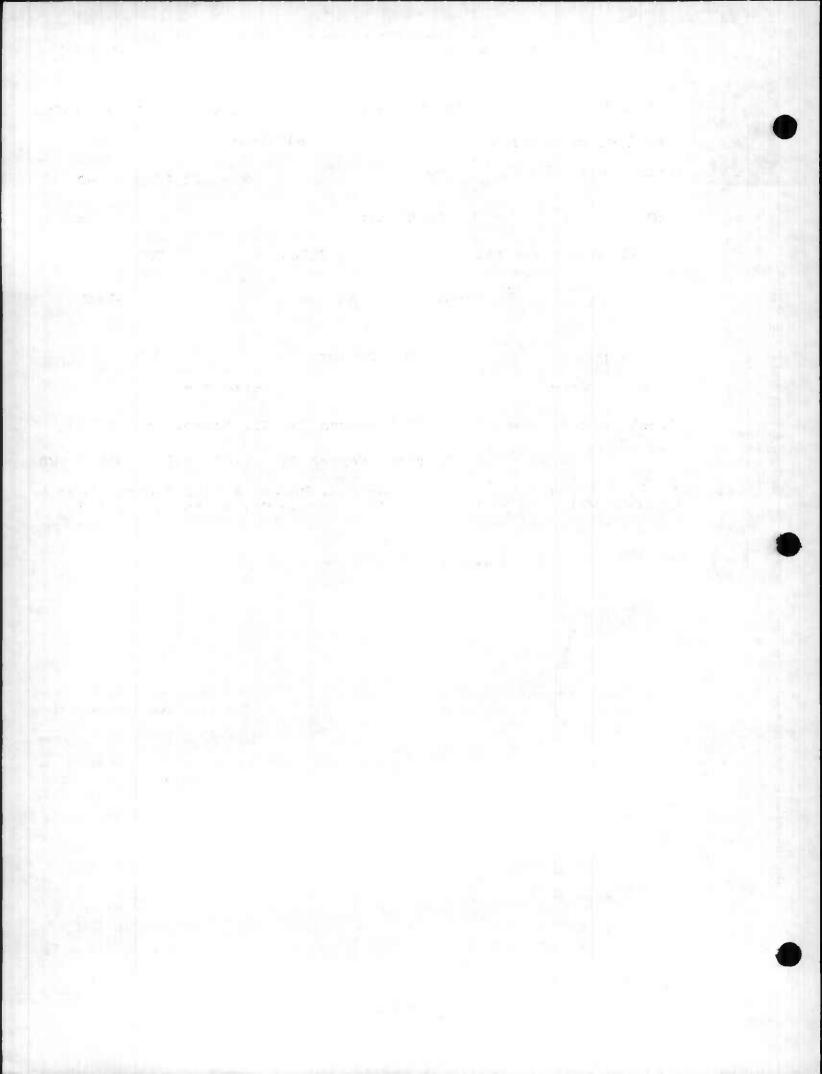
Il Director: After this certificate of in by the funeral director, pe 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28h Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 SNeturel 5 Pending 1□Yes 2□No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital of within 24 hours a To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. Medical 29e. Certifier 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dacker Varitack, M.D. 47813 January 30 1998 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

BASHAR KARAKASH 3007 E. NORTHERN Parkersy Ballimore MD 21214

State Registrar 31. Data filed (Month, Day, Year) JAN 3 0 1998





111 Penn Street, Baltimore, Maryland 21201

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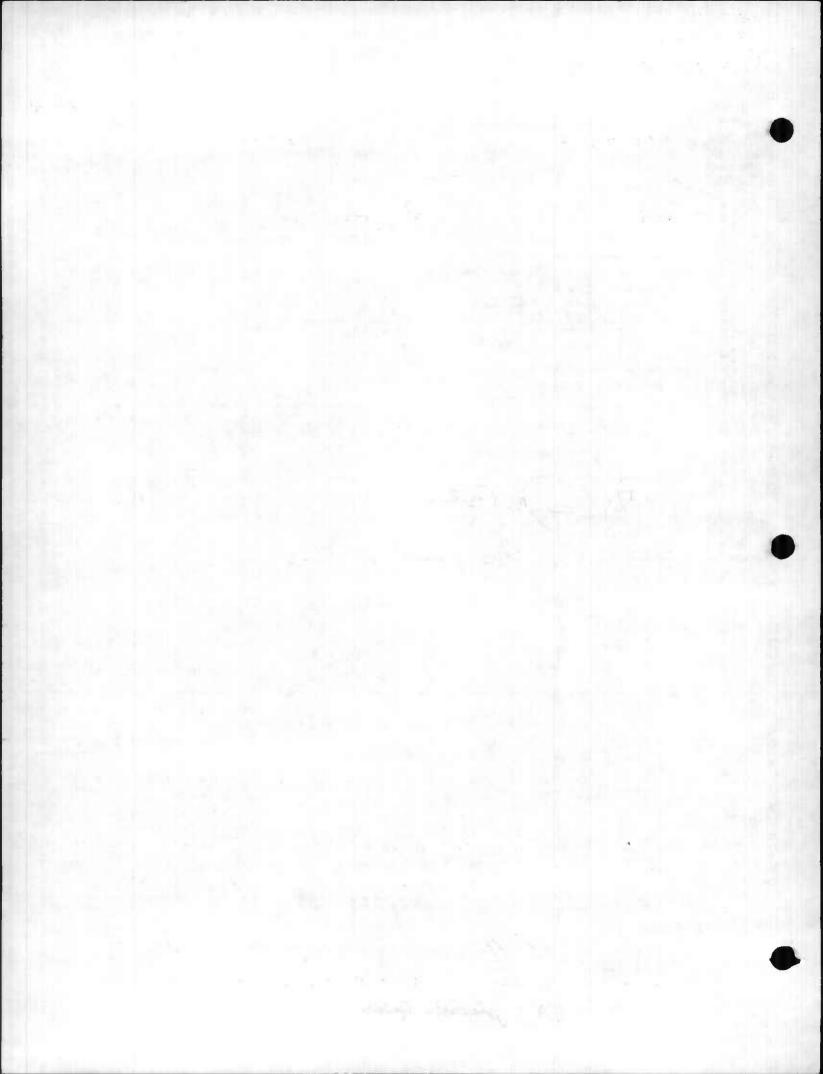
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JAN 3 0 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muler

Davidson-Randell



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Darothy E. Tydings AN. 25,1 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Mariner Health of Bel Air Bel Air Harrford If Under 1 Yeer If Under 24 Hrs. | Months Deys Hours Min. 5. Sociel Security Number 8. Dete of Birth (Month, Dey, Year) May 15, 1912 7. Age (In yrs. last birthdey) 9. Birthpleca (State or Foreign Country) Baltimore City, Md. 1 M 2 XF Yrs. 216-24-3466 Usual Residence of Decadent 85 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Harford Abingdon 1 ☐ Yes 2 ☑ No Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21009 9 Aiken Terrace USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 14. Reca - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 N/A Housewife Housekeeping-Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) William Miskelly Dora Schultz 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9 Sharpley Court Baltimore, Maryland 21234 Robert Coleman 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 □ Donetion 5 □ Other (Specify) Parkwood Cemetery January 28, 1998 Baltimore, Maryland 21. Signature of Funerel Service Licanses 22. Neme end Address of Fecility Lassahn Funeral Home, Inc. 1 arun 7401 Belair Road Baltimore, Maryland 21236-4625 mer 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List pnly one ceuse on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Cerebro vascular accident ms Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Nulntim 1 Yes 2 No 3 Probably 4 Unknown 010 24b. Were eutopsy findings evalleble prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of Injury 28c. Injury at Work? 1 Wature 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, end due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. 29e. Certifier (Check only one)

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29b. Signeture and title of certifier

MD

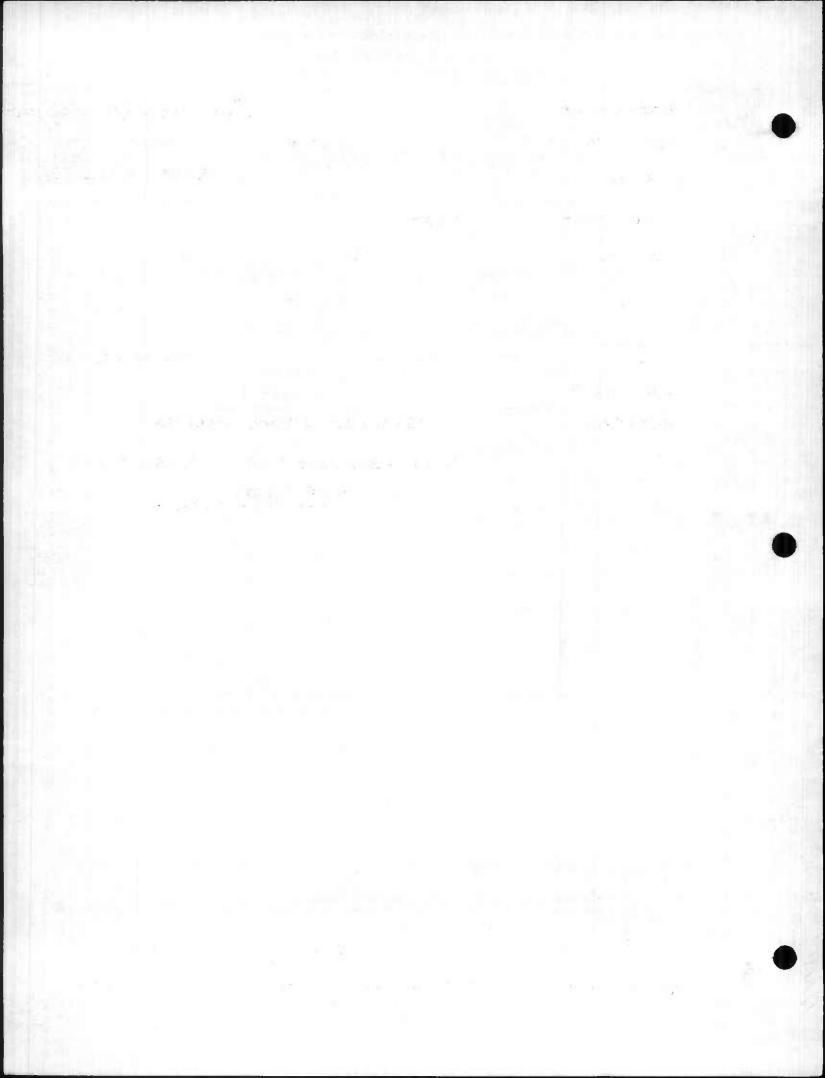
29c. License number

29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

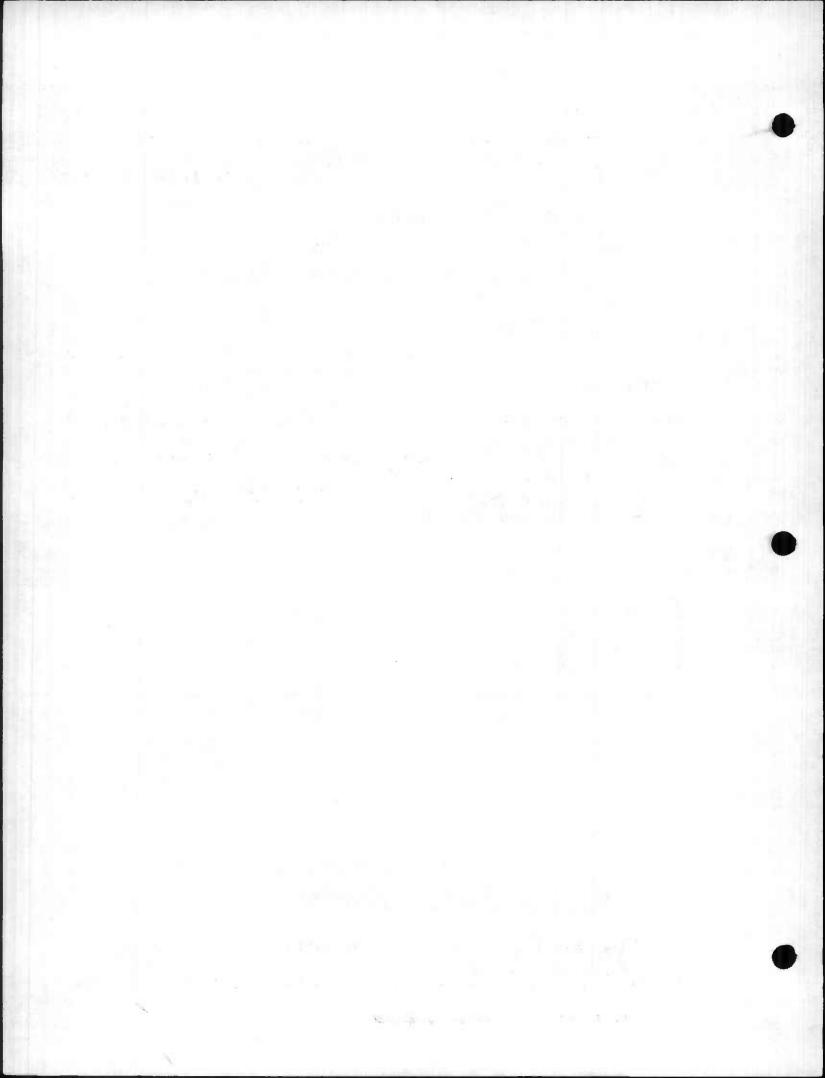
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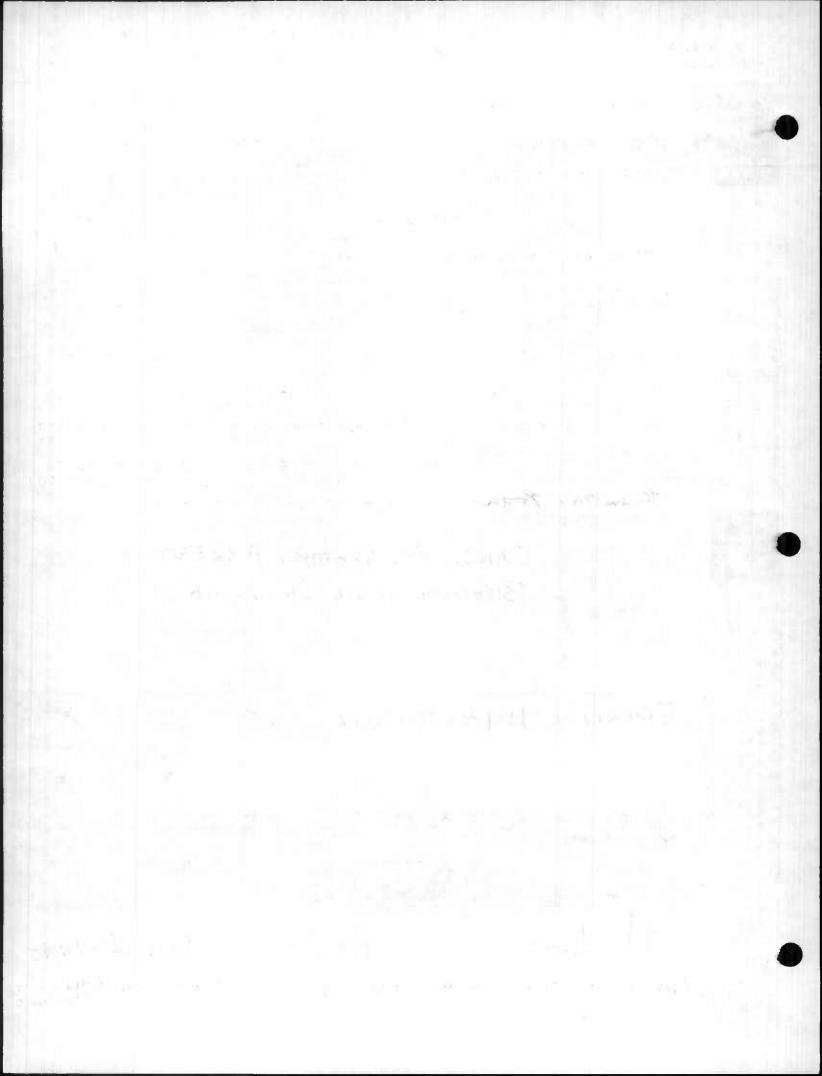
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If Under 1 Year II Under 24 Hrs. 8. tospita ylana General 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country)
 // 1 M 2 XF Deys 226-18-8140 Yrs Va Usuel Rasidenca of Dacedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Hmore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 120 Shields 1125 lace , SA 12. Wes Decedent Ever In U,S. Armed Forces?

1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Married Black 1 ☐ Yes 2 ♥No Specify: Specify: 3 DeWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1,4or 5+) omestic grade 7 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Surneme) Mari E Lyles 021er 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Aurel Route Number, City or Town, Stete, Zip Code) 2365 Daughter Balto, my Netmea 21209 orwhu Terrace 20b. Plece of Disposition (Neme of pemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 150h 21. Signeture of Funerel Service Licansee 23e. Pert1. Entar the disease, or complications thet caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. es Approximete Intervel Between Onset end Deeth Immadiata Ceusa (Final disease or condition resulting in death) Due to (or es e consequenca of) neumonia Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceusa (Disaese or Injury thet initiated avents resulting in death) Lest Due to (or es e consequenca of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of daeth? 24e. Wes en eutopsy performed? 2 DINO 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 27. Mangar of Deeth 28d. Dascribe how injury occurred

Box 68760. P.O. 1 Records, Division of Vital

Examiner ettending physician and for use es the burial-transit The law requires that the deeth certificate be executed signed b icete has been sig r, pege 2 should b this certificete To the Hospital or Attanding Physician: within 24 hours efter death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p

Physician

/Medical

Examiner

Funeral

Director

28a-f show

9

"natural", or items 23a

permit. Pages 1 and 2 should be filed within 72 hours effer Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite

Baltimore, Maryland 21215-0020

lannison, Mary

Director

by

Completed

traumatic event, the Madical Exertiner must be notified at

othar 1

Physician /Medical

Examiner

Physician/Medical Aq Completed Be Certification: To

Medicai

State Registrar 25. Was case referred to medical

1 Netural

2 Accident 3 Suicide

4 ☐ Homicide

(Check only one)

29a. Cartifiar

5 Panding Investigation

6 Could not be

28a. Dete of Injury (Month, Dey Year)

28b. Time of

28c. Injury et Work? 1 Yes 2 No 28a. Placa of Injury - At homa, ferm, street, factory, office building, atc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

10 Certifying Physician: To the best of my knowledga, death occurred et tha time, date end pleca, end dua to tha cause(s) end mennar as statad.
2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, daath occurred et the time, dete end placa, and due to the cause(s) and menner statad. 29b. Signeture end title of certifier

MD

29c. License number

29d. Date signed (Month, Dey, Year)

eddress of person who complated cause of gaath (Itam 23a) (Type, Print) eth Geh. M.D. To Mary land

31. Dete filed (Month, Dey, Year)

32. Registrar's Signetura July Davidson-Mandree

DHMH 16 Rev 6/95

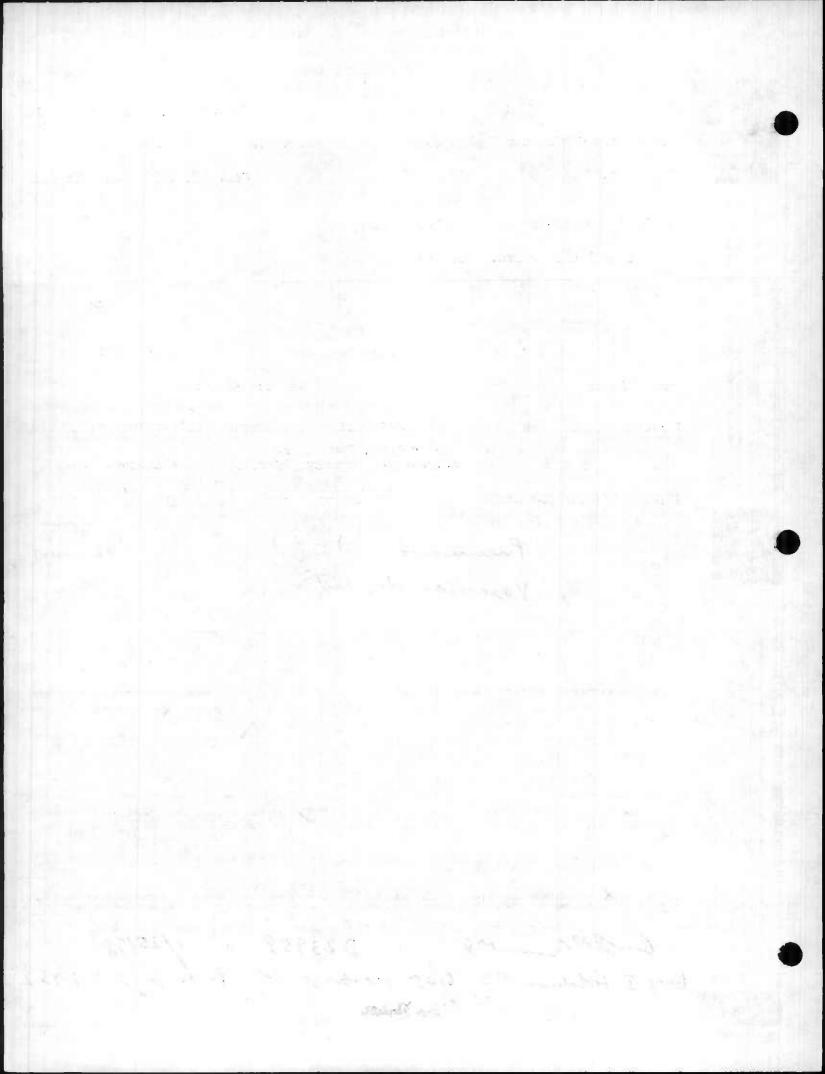


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

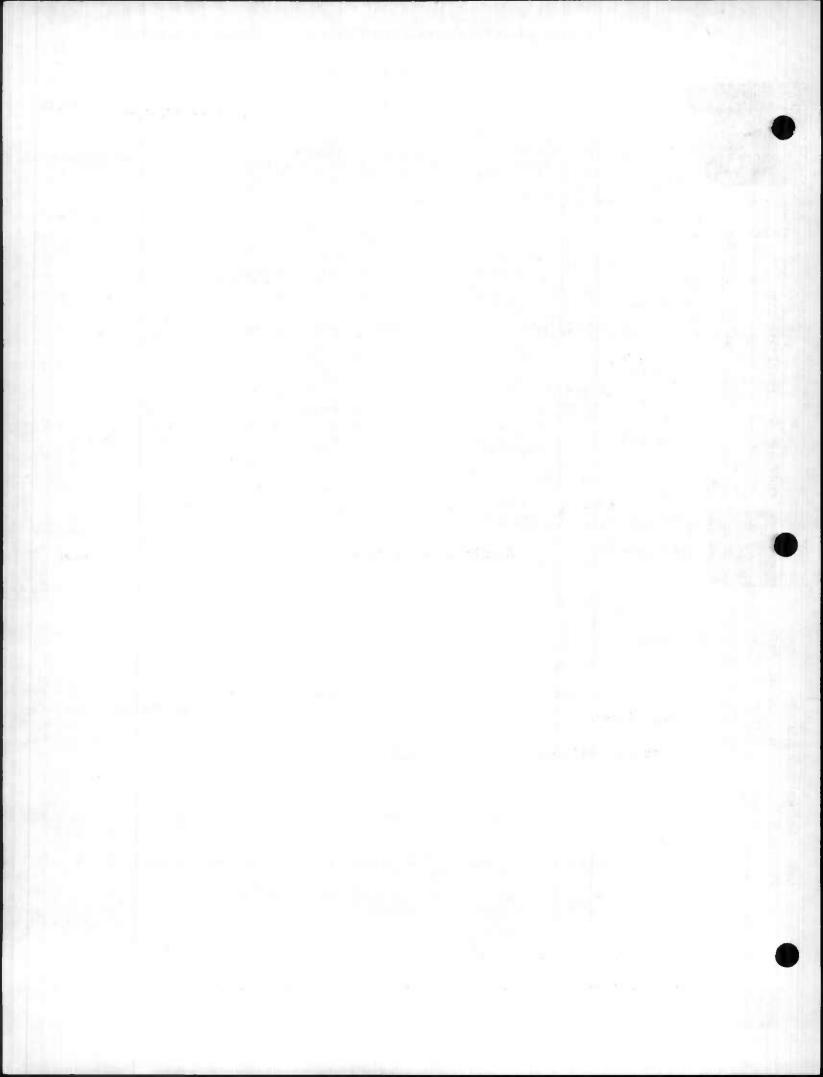
Per No. 2468

						(Certifica	ite of	Death		R	eg. No.	0 (12468
Dhu	alala		1. Decedent's Name (First, Middle, Les	it)			10				2. Dete of Deet Month	-	Yeer	3. Time of Death
Phy: /Mc	sicia edic	_	ELI V	IENER							January	•		1:35 A.M.
	min		4e. Fecility Name (If not institution, give						4b. City, To	wn, or Lo	ocation of Deeth		inty of Dee	
			Hebrew Home Of Gr	The second second					Rockv		2	Mo	ntgom	ery
Fune Direct			5. Sociel Security Number 578-20-5639 Usual Residence of Decedent	9x 7. 13km 2□ F	Age (In yrs 79		Month	er 1 Year s Days		24 Hrs. Min.	8. Date of Birth (Month, Day, Oct. 13	Year)		thplace (State or Foreign puntry) Bt Virginia
y w	2		10a. Stete 10b. County		10c. Ci	ty, Town	or Location							10d. Inside City Limits
ith the Marylar or 28a-f show		Director	Maryland Montgom 10e. Street end Number	ery	Si	1ver	Sprin 10f. 2	g lip Code			1	0g. Citizen	of Whet Co	tountry?
23a 23a		je	15100 Interlachen	Drive,	Apt.	815		2090	6			U.S.	Α.	
filed within 72 hours efter death with the Maryland thygiene. Hygiene 19a or 28a-f show ther the mark to notine and hit.	TOTAL STREET	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 [XYes 2] If Yes, Give Year or Date	□No		13. Wes Dec				ecify Yes or No- Ricen, etc.)	E	Bleck, Whit	ericen Indian, ie, etc.
d within 72 hours of gione. or than "natural", or		ted	15. Decedent's Edu	ucetion		16e. E	Decedent's Us	uel Occu	pation			16b. Kind o		
S should be filed within 72 ho end Mental Hygiene. Is marked other than "natus eumatic event.		Completed	(Specify only highest gred Elementery/Secondary (0-12)	College (1-40 4 Years	or 5+)		Decedent's Us Give kind of v life. DO NOT Siness			t of worki	ing	Scra	p Met	al
d 2 should be filed th end Mental Hygi 7 is marked other treumatic event.		Bec	17. Fether's Name (First, Middle, Lest)			1			18. Mothe	r's Neme	(First, Middle, M			
should be nd Mental marked o		To B	Hyman Viener						Reb	ecca	Mozent	er		
d 2 should th end Men 7 is marke treumatic			19a. Informent's Name/Reletionship (T	ype, Print)		19b. I	Mailing Addre	ss (Stree	t end Numbe	er or Rure	al Route Number	City or To	wn, Stete, 2	Zip Code)
of Health of Health fitem 27			Jonathan Viener, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ I 4 ☐ Donetion 5 ☐ Other (Specify)	Removel from Sta	te Ohe	Plece of E	Disposition (N OTOM T ation	eme of almu Ceme	d ^{e)} Tora	h /26/	Dete /1998	20c. Locatio Washi	on - City or ngton	ng, MD 20902 Town, State
permit. Peg Depertment Important: I	once		21. Signature of Funeral Service Licens Wr. & Keeduling	Sinte			232 C	ARRO	LL STR	REET,		SHING		INC. DC 20012
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Examin			disease or condition resulting In death)	. Pre	un	on	3							12 hours
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and and I-trensit		Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying	b. Van			nsequence of		VW4					rans
certificete be executed iding physician and ise es the buriel-trensit		edical	ceuse. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting In deeth) Lest	С.	Due to (c	or as e co	nsequence of):						
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es that the de igned by the be deteched		by Physician									1 🗆 Ye	()		robably 4 Unknown
aw requires been size should		Completed									24e. Wes er perform	n eutopsy ned?		Were eutopsy findings available prior to completion of ceuse of deeth?
The law ate hes b		O									1□ Ye	s 2 No		1 ☐ Yes 2 ☐ No
			25. Wes cese referred to medicel exeminer?						26. Plece	of Deeth	(Check only on	ө)		
d is		0	1 Yes 2 No	Hospitel: 1 ☐ Inpa	tient 2	ER/Outp	atient 3 C	OA Ot	her: 4 Nu	rsing Hor	ne 5 🗆 Reside	nce 6 🗆	Other (Spe	city)
nding ath. r: After			27. Manner of Death 1 Naturel 5 Pending 2 Accident investigation	28e. Date of In (Month, L	jury Day Year)	28b. Tin Inju		28c. Inju Wo	iryet ork?]Yes 2 □ l		28d. Describe ho	w injury oc	curred	
To the Hospital or Attend within 24 hours effer death To the Funeral Director: / completely filled in by the		Certification:	3 ☐ Suicide 6 ☐ Could not be determined		etc. (Specif	y) 					City or Town	, State)		urel Route Number,
he Hosp in 24 hou he Fune pletely fi		edical	29a. Certifier (Check only one) Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one) Certifier (Check only one) Certifying Physical Certifying Physical Certifier (Check only one) Certifier (Check one)	sician: To the bes ner: On the basis end manner	of examine	wledge, d	death occurre or Investigetio	d et the ti n, in my d	me, dete end opinion, deat	d plece, e th occurre	end due to the ce ed et the time, de	euse(s) end ete end plac	manner as e, and due	s stated. to the ceuse(s)
To the Com		-	29b. Signeture and title of certifier Audilles		25				se number 2 3 9 5	-8				h, Dey, Year)
DH.			30. Name and address of person who co	ompleted ceuse of		105	ype, Print)	ntr	oze	Rd	for-	kril /	2, 1	00 2085 2
	State	9	31. Date filed (Month, Day, Year)	32. Re	lia Age	ture	Parel 00							



State of Maryland / Department of Health and Mental Hygiene 8

				(Certifica	te of	Death		Reg. No.	C. Jane	, ,	
Physiciar /Medica	_	Decedent's Name (First, Middle, Las	"Vernon	и	Theel	er	Sr	2. Dete of De Month	Dey	Yeer		e of Deeth
Examine Funeral Director	er	250-36-2711	ospital	yrs. lest birthe	Months	er 1 Yea	If Under 24 Hrs.	Location of Deef	4c. County	of Deeth	place (Ste	ete or Foreigr
within 72 hours after deeth with the Maryland ane. then "naturel", or items 23s or 28s-f show he Medical Examiner must be notified at		Usual Residence of Decedent 10e. State 10b. County M ()		C. City, Town			10.0			1		e City Limits Yes 2 □ No
eth with the 23a or 28 sust be not	rai Director	10e. Street end Number 622 Brisban	ne Road		10f. Z		229		10g. Citizen of V	Whet Cour	ntry? A	
el', or hems	by Funeral	11. Maritel Status 1 Never Married 2 Merried 3 Wildowed 4 Divorcad	12. Wes Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	in U,S.	13. Wes Dece If Yes, spi 1 Tyes	10	Hispenic Origin? (S ben, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	- 14. Red Blee	ck, White,		
Hygiane. ther than "natur ant, the Madical	Completed	15. Decadent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation (e completed) College (1-4or 5+)	(0	Decedent's Using Sive kind of wife. DO NOT the Canal C	ork done use retir	e during most of wor ed)	rking	16b. Kind of B	usiness/In/ UM Plaz	bia	
and Mentel Hygia s marked other t numatic event, the	10 Be C	17. Fether's Neme (First, Middle, Last) Ing Wheel-	er				18. Mother's Nar Mart	ne (First, Middle,	Maiden Sumen	1		
		19e. Informent's Neme/Reletionship (7) May Ha Hoy Hoy 1 20e. Method of Disposition 1 \$\sum_{\text{P}}\$Buriel 2 \$\sum_{\text{Cremetion}}\$ Cremetion 3 \$\sum_{\text{I}}\$	Removel from State	ter 62	22 Br	s ba	en e Ro eca)	Date	0	ore	Hd	2/229
Depertment of Health Important: If Item 27 any injury or other treatment.		4 □ Donetion 5 □ Other (Specify, 21. Signature of Funerel Service Licens)	19e C 22. Name e May	ng Addi	chuch ess of Fecility F. H. Wk	1-31-98 of Ang	Due B	90,	Ma	21215
hysician /Medical xaminer	e e	23a. Pert1. Enter the disease, or comp shock, or heart feilure. List only o immediate Ceuse (Final disease or condition resulting in deeth)	Anoxic E		lopath	y	ing, such es cardiad	c or respiretory e	rrest,		Approxir Intervei Onset ei	Between and Deeth
for use es the burial-transit	Medical	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in deeth) Lest	c	to (or es e con								
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rthis certificate hard director, pege	0	25. Wes case referred to medical exeminer?	de catal					ath (Check only o	Yes 2□No	13	Yes 2	2□ No
or death. ector: After this by the funeral di		1 Yes 2 No 27. Menner of Death 1 Noturel 5 Pending investigation 3 Sulcide 6 Could not be determined	All 1 All 1		ne of ury M	28c. inje We	ury et ork? ☐ Yes 2 ☐ No		how injury occur	red		Vumber,
ne Hospital or no 24 hours after ne Funeral Dir pletely filled in		29a. Certifier 1 ☐ Certifying Phy (Check anly one) 2 ☐ Madical Exami	sicien: To the best of my ner: On the basis of exam	knowledge, o	death occurred or investigetion	d et the t	time, date end piece opinion, death occu	o, end due to the irred et the time,	cause(s) end mo	enner es s	iteted.	se(s)
within 2 To the comple	2	29b. Signature and titlerot certifier	end manner steted.	N			se number	J	29d. Date signe			ir)
3 State		30. Name and address of person who countries of the person		Agnes		hCar	e - Balti	more, M	aryland	212	29	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Jan. 24° 1998 ear **JOHN FERGUSON** WILLIAMS 6:35pm /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yeer) Aug. 31, 1918 Washington Adventist Hospital Prince Georges 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (Stete or Foreign 180 M 2□ F Months Yrs. 226-10-1679 79 Virginia Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 No 2 No Prince Georges Maryland Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4534 Natahala Drive 20735-4313 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22☐ No If Yes, Give Year or Dates: Race - American Indian, Bleck, White, etc. 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: specify: Afro-American P 3 Widowed 4 Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Manager Insurance Company 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) Be George Williams Nannie Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ms. Kimberlyn I. Hall (niece) 5015 Colburn Terrace, Hyattsville, MD 20782 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State Jan 1998 ty☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Morris Community Cem. Hume, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JOYNES FUNERAL HOME, INC. 29 N. 3rd. Street, cations that can bed the death. Do not enfer the mode of dying, such as cardiac or respiratory arrest, as can each line. 29 N. 3rd. Street, Warrenton, VA Approximete Interval Between Onset end Death Immediate Cause (Final Arnomodas unitasiigaA disease or condition resulting in death) Due to (or as a consequence of): ALZEIMER' DILEASE Examiner Due to (or es a consequenca of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting In deeth) Last CAMBOINDEMMER BUEEBING Physician/Medical Due to (or as e consequence of): Part II. Other stgnificant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? noth ASIGKA 1 Yes 2 No 3 Probably 4 Unknown þ RENAL EAILURG 24b. Were eutopsy findings available prior fo completion of cause of death? Be Completed 24a. Wes en autopsy performed? 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? examiner/ 1 ☐ Yes 25 No Hospital: 1 Dnpatient 2 ER/Outpatient 3 DOA Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Natural 5 Pending investigation 1 Yes 2 No 2 Accident 8 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Piaca of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifler 1 Certifying Phystelan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature end title of cartifier 29c. Licanse number 29d. Datę signed (Month, Dey, Year) 01/24 9971

TAKUMA

State Registrar

Funeral

Director

r than "natural", or items 23s or 28s-f show The Medical Exampler must be notified at

permit. Pages 1 and 2 should be file Department of Haalth and Mentel Hy important: If them 27 is marked other any injury or other traumatic event once.

Physician /Medical

Examiner

physician end s the buriel-transit

signed by

pege 2 should

funeral

After

To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

The law requires that the death certificeta be executed

P.O. Box 68760,

Records,

Division of Vital Hospital or Attending Physician:

daath v

filed within 72 hours efter

Baltimore, Maryland 21215-0020

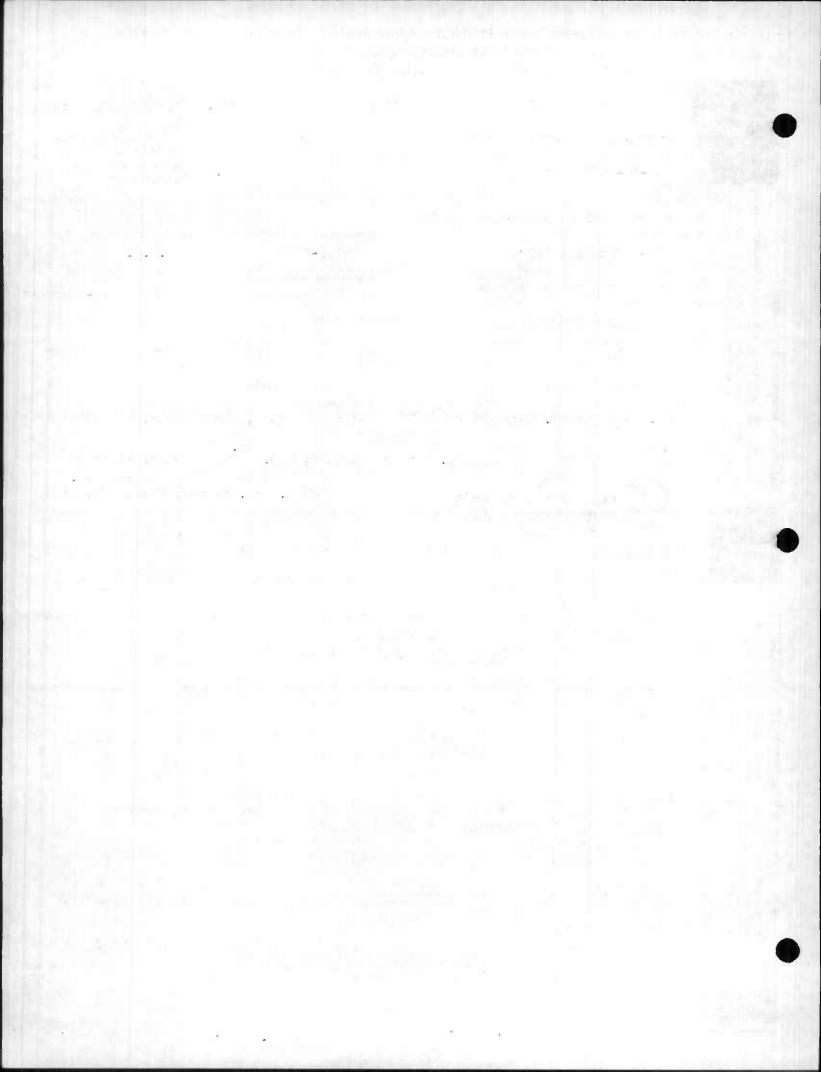
31. Dete filed (Month, Dey, Yeer)
JAN 3 0 1998 32. Registrar's Signature
Fina Davidson-Randall

7610

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. TUOHAKAR MO 7610 (ARRULL 1YE

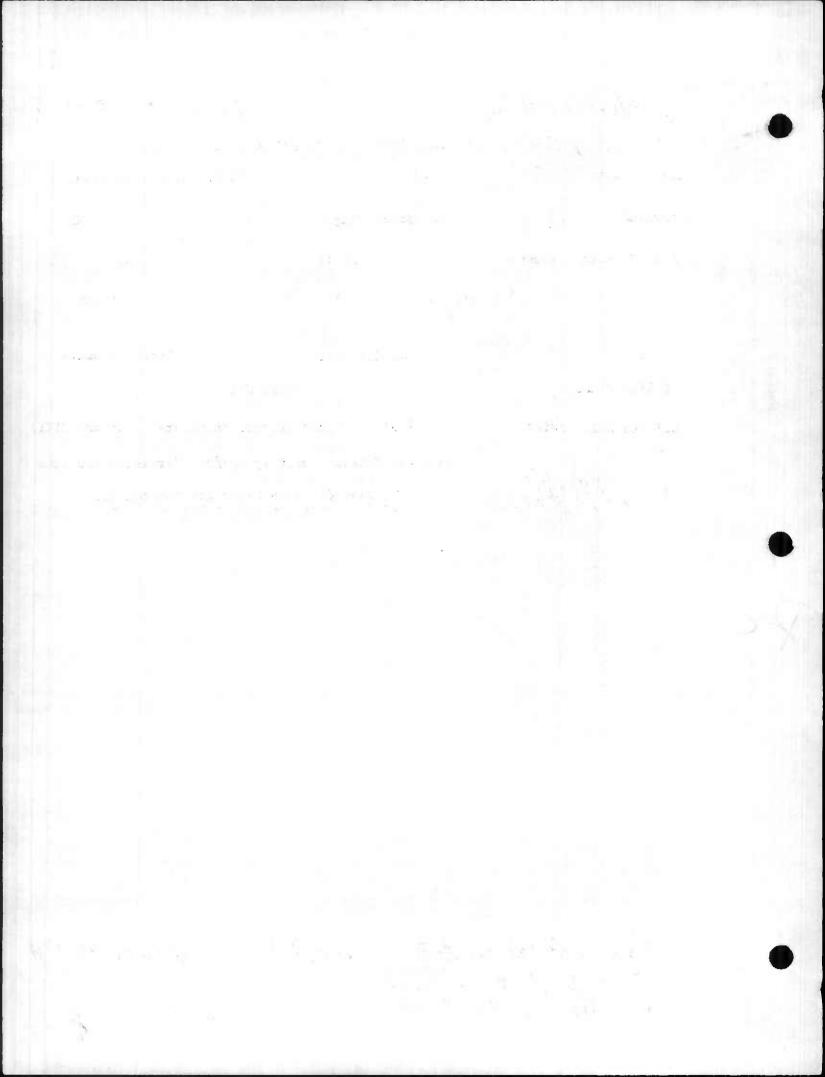
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State of Maryland / Department of Health and Mental Hygiene 8 0 2 4 7 |

Certificate of Death Reg. No.

ician		I. Decedant's Nama (First, Middla,	Last)						2. Data of De Month	ath Day	Year	3. Tima
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niner	1.0	a. Facility Nama (If not institution,	give street and nu	mber)	1		4b. City, T	own, or Lo	cation of Daat	h 4c. Cou	nty of De	ath
	Г	Liberty	Medil	11/ 6	finte		13/11	1tim	ore,	N/	٨	
al	5	Social Sacurity Number	6. Sax	7. Aga (In yrs.	last birthday)	If Undar 1		r 24 Hrs.	8. Data of Bi (Month, Di			irthplace (State
or	2	13-28-4439	11XM 2□ F		67 Yrs.	Months [Days Hours	Min.	11-22-			ryland
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Ö	M	Maryland N/	A	Ва	altimor	e Cit	У					N Y a
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by F		1 Navar Marriad 2 Marrie	If Yas, Gi	2 No va 11/2/1	51 1	☐ Yas 2☐	XNo Specify	y:		Spe	city: F	Black
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		Delores while /	WILE	20b. P	laca of Dispos	sition (Nama	of	vende	Data			r Town, Stata
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DUCE	28	21. Signature of Funanti Service Li	Ophalia /		22.	. Nama and A	Addrass of Faci	ility				
ă		1/179	1401114	U	Wi	lliam	C. Bro	wn Cn	mmunit	y Funer	ral E	lome
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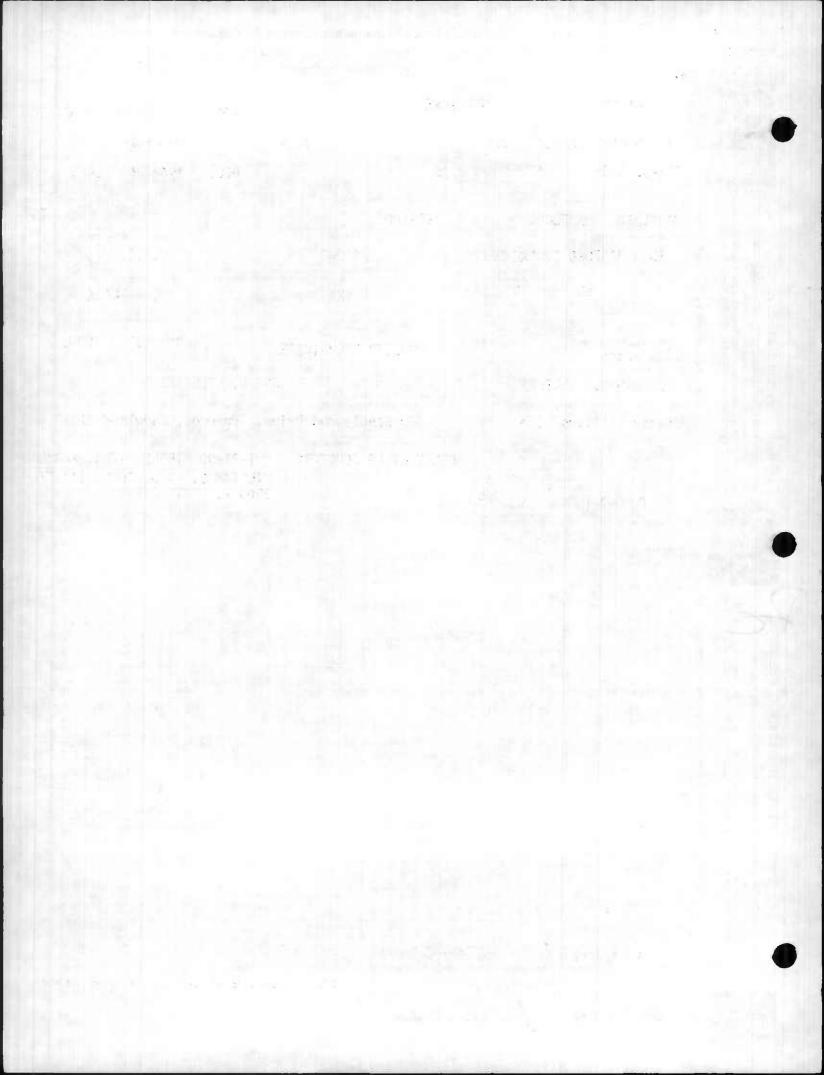


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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

ANTHONY

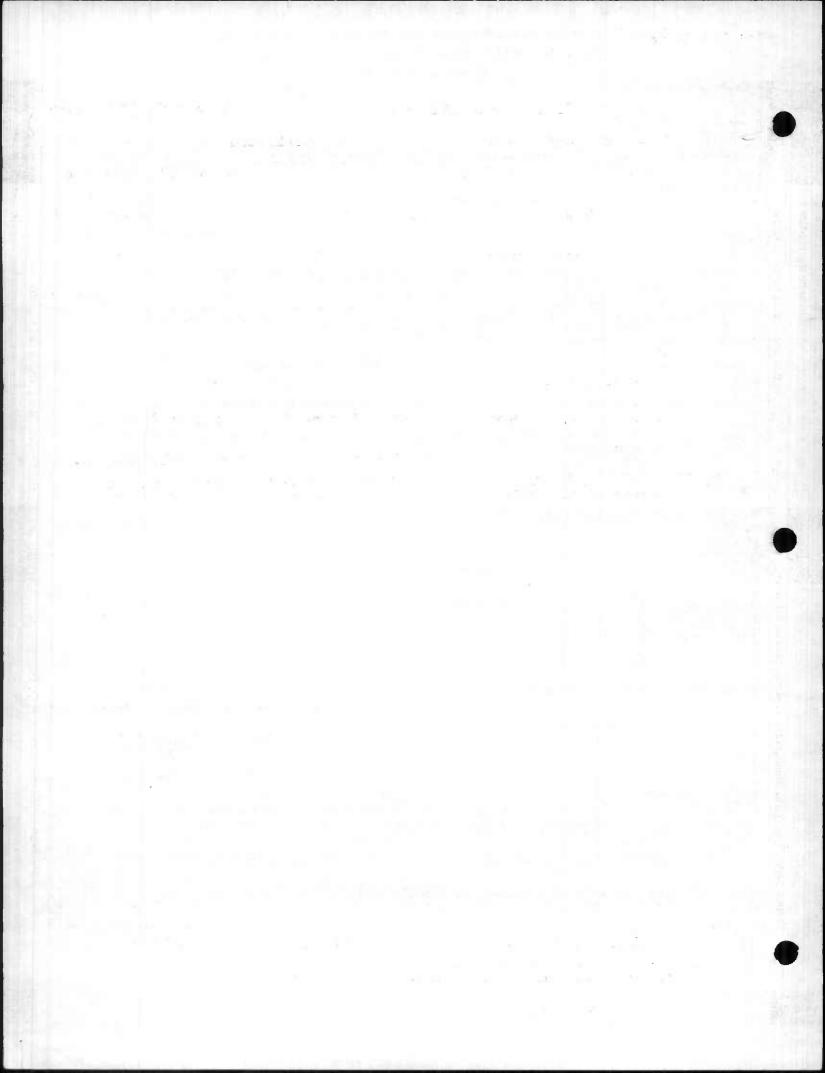
ician	1. Decedent's Name (First, Middle,	Last)						2. Date of D	Reg. No. Death	Year 3.	Time of Deeth
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al or	5. Social Security Number 213-92-1358		Age (in yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hr. Hours Mir	s. 8. Date of B	lirth		(Stete or Foreign
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to	MARYLAND HARFO	RD		EDGEWO	OD					1	☐ Yes 2XXNo
Olrec	10e. Street end Number				10f. Zip	Code			10g. Citizen of \	Whet Country?	
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ပိ	12th grade 17. Father's Name (First, Middle, La	st)		QOIL		LOTTI		ame (First, Midd	le, Meiden Suman	ne)	
To Be	BERNARD C. WILL	IAMS					DIANNE	E L. WIL	LIAMS		
	19a. informant's Name/Reletionship								ber, City or Town,		
	Stacey Williams/ 20a. Method of Disposition	Wife	20h	500 (d Drive	, Edgewo	od, Mary	City or Town,	-
	1 Surial 2 Cremation 3 4 Donation 5 Other (Spe		ate	cam <i>etery</i> , crer	LS C	ther pla					MARYLAND
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dicai		Physician: To the beaminer: On the basi and manne	s of examine								
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	30. Name and address of person wh	^		m 23a) (Type,							01601
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State of Maryla

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tificate of Death	Reg. No.	0	U	4	Ch	1	i.

29d. Date signed (Month, Day, Year)

JANUARY 24, 1998

Physician	
/Medical	
Examiner	

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be not the page. Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

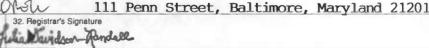
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1 ☐ Never Married 2 ☐ Married	Armed Forces				0	an, Mexica	n, Puerto	Rican, etc.)			k, White,	
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20a. Method of Disposition		20b. P	lace of Dispos	ition (Nen	me of	cel		Dete	20c. Lc	ocation -	City or To	own, State
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21. Signature of Funeral Service Licen	see del	201	22.	Name an ESTI 1300	O EU	ROTHE	RS F	FUNERAL BALTO. N	HOME	E P.,	A.	
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29c. License number

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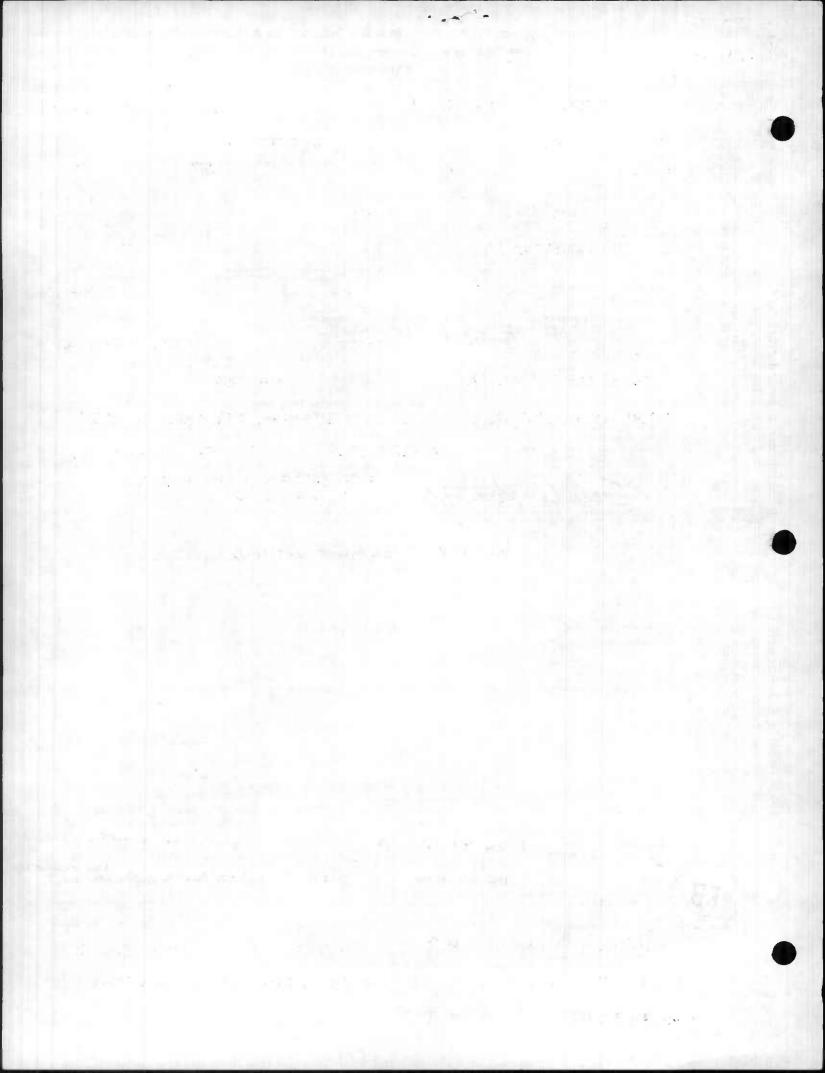
State Registrar

30. Name and eddress of person MARYDON



who completed cause of death (Item 23e) (Type, Print)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dev **Physician** Louise January 28, 1998 ation of Death Janet 9:08am /Medical Warner 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Jan. 1, 19 If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplece (Stete or Foreign Country) **Funeral** Months Deys Hours 1 M 2 F 1921 Minnesota Director 475-18-9289 Usual Residence of Deceden the Merylend 10c. City. Town or Location 10d Inside City Limits r 28a-f show 10e Stete 10b. County Yes 2□No Directo Anne Arundel Annapolis 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? Hygiene. pther then "natural", or frems 23a or " rent, the Modical Examiner must be a death with USA Funeral 2544 West Course Drive 21401 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter lent of Health end Mental Hygiene. 1 Never Married 2 STMarried 1 Yes 2 No Specify: Specify: White g 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 7 is marked other traumatic event, I 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) John C. Hustad Adelaide Lillian Newstrom 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) or other tra Franklyn C. Warner - Husband 2544 West Course Drive, Annapolis, MD 21401 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Depertment of Important: If any Injury or once. Metro Crematory 1/30/98 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Maryland 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD arcobi 1 nomas 21401 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner ronary artery end I-transit the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or as e consequence of): physician er Box 68760 Physician/Medical Due to (or as a consequence of): 98 use. ò signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other elanificent conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown that Ision of Vital Records, by 24b. Were eutopsy findings eveileble prior to completion of ceuse should 24a. Wes en eutopsy performed? Completed The law certificate has t lirector, page 2 s 1 ☐ Yes 2 ☐ No 1 Yes 2 No Attending Physician: director, 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28c. Injury et Work? 27. Menney of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Neturel death. 1 Tes 2 No 2 Accident tor 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) e Hospital or Atten 24 hours effer de le Funeral Directo 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) end manner as steted. edicai 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only To the I 29d, Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number

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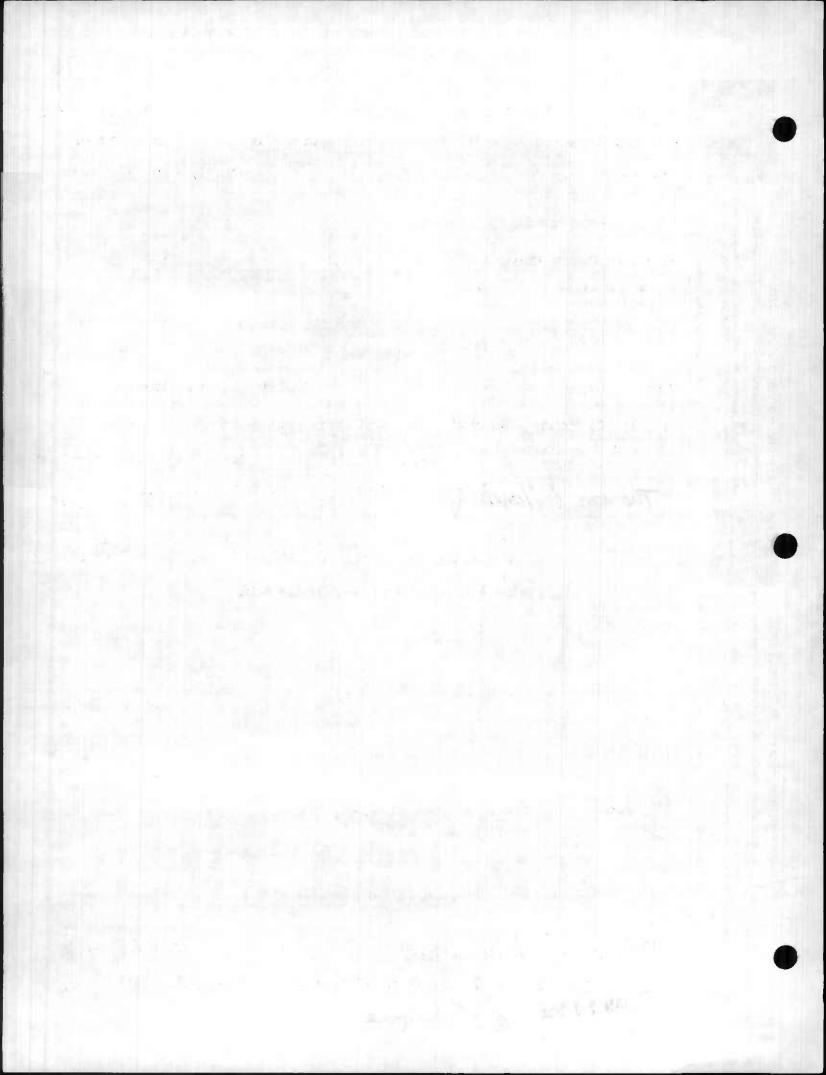
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State Registrar Cel

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

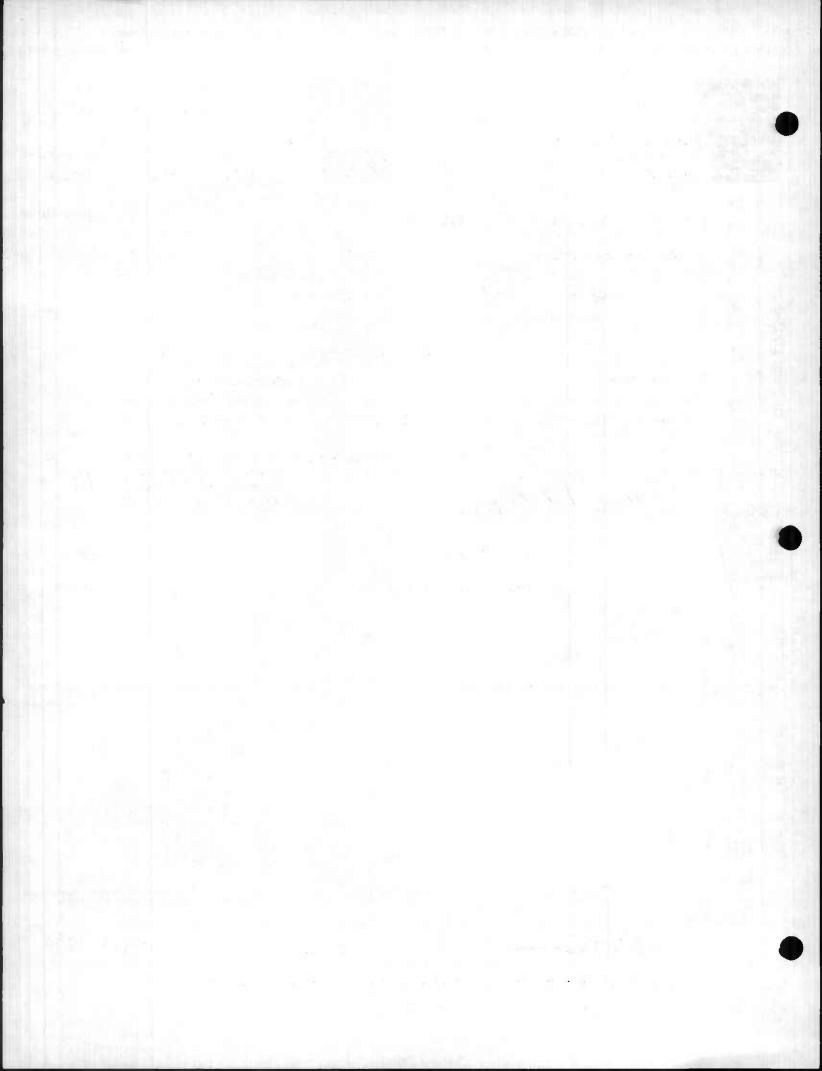
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32. Flegistrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

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amine	-	4e. Fecility Neme (If not institution,	give street and n	um <i>ber)</i>			4b. City, Tov	wn, or Location		4c. County			
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r	-	191-12-2160 Usuel Residence of Decedent	1½M 2□ F	/	4 Yrs.		1100.0			1923	Penns	ylva	nia
		10e. Stete 10b. County		10c. (City, Town or L	ocation					1	Od. Inside	City Limits
Director	PCIO	Maryland Harfor	d	Ве	l Air								es 2 No
		10e. Street end Number				10f. Zip Code	C		10	og. Citizen of	Whet Cour	itry?	
Finaral	2	1001 Shaffner Dr				21014				nited			
2	5	 Marital Status Never Married 2 Marrie 	Armed F		0,8.	Wes Decedent of If Yes, specify Co	i Hispenic Orig iben, Mexican,	, Puerto Rican	es or No- , etc.)	14. Had	ce - Americ ck, White,	an Indien, etc.	,
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L	2	Irvin Wier						herine					
		19e. Informant's Name/Reletionshi				ng Address (Stre					, Stete, Zip	Code)	
		Bruce E. Wier -	son	no.		Shaffne	r Drive				014		
		20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3	☐Removel from		cemetery, cre	osition (Name of matory or other p	lace)	Det	e 2	Oc. Location	- City or To	wn, Stete	
		4 ☐ Donetion 5 ☐ Other (Spe		Ge		ington M							PA
4		21. Signeture of Funeral Servica Li	ensee		2:	2. Neme end Add	ress of Fecility	McClur	e Fun	eral H	ome,	Inc.	
		Dama 1	hell	na				Stento Plymou	n Ave	eting.	tler	Pike	
		23a. Part1. Enter the disease, or or shock, or heert failure. List or	implications that	caused the de	eth. Do not en	ter the mode of d	ying, such as o	cardiac or resp	lretory erre	st,		Approxim Intervel B	nete
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ne	2		Cong	estive	Heart I	Tailure					2	yea:	re
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		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury									i		
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13		3 Suicide 6 Could no	be and Dies	e of Injury - At	home, farm, str	eet, fectory, offic			cation (Str	eet and Num!	oer or Rura	I Route No	um <i>ber</i> .
E		4 ☐ Homicide	build	ling, etc. (Spec	ify)	,		Ci	ty or Town,	State)			
Ole		29a. Certifier 17 Certifying	Physician: To the	e best of my kr	owledge, death	occurred et the	time, dete end	I place, end du	e to the ce	use(s) end mo	enner es st	eted.	
edical		(Check only 2 Medical Ex	aminer: On the t end mer	pasis of examination of steteod.	etion end/or in	vestigetion, In my	opinion, death	n occurred et t	he time, de	te end piece,	end due to	the ceuse	e(s)
Σ	1	29b. Signeture end title of certifier				29c. Lice	nse number			d. Dete signe			
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	3	30. Name end eddress of person wh	o completed cau	se of deeth (Ite	m 23e) (Type,						1		
		Dr. Sherif Osm			ille Ro		l Air,	MD 21	014				
State	:	31. Dete filed (Month, Day, Year)	0 .32.1	Registrar's Sign	nature	du De	- uit)	41 بيد	014				
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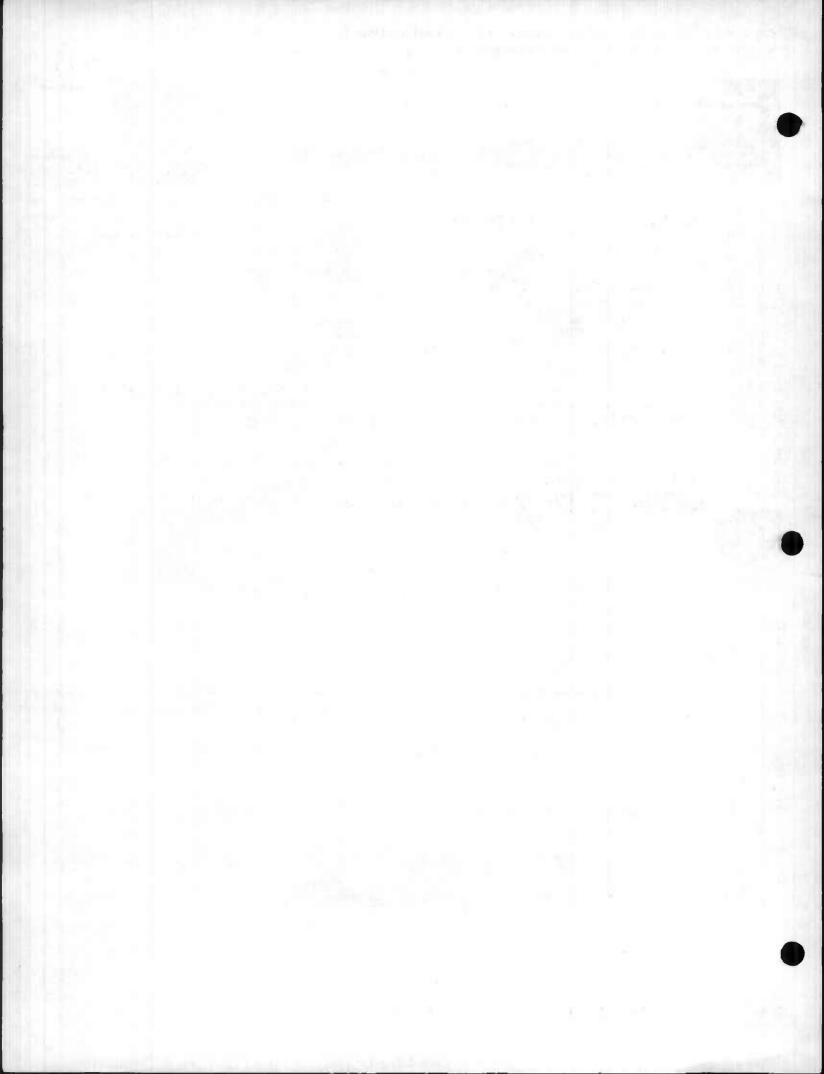
State of Maryland / Department of Health and Mental Hygiene

				Certificate of L	Death	Reg. N	10.98 U	2411
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	Physici /Medi		ANDREW JOHN	YUCKA	J	ANUARY	28, 1998	6:15 AM
	Examir		4e. Fecility Neme (If not institution, give street end number)	41	b. City, Town, or Local		c. County of Deeth	
			JOHNS HOPKINS BAYVIEW MED		BALTIM		N/A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. lest bit 187 – 12 – 2444 7. W 2□ F 7. Age (In yrs. lest bit 78	rthday) If Under 1 Year Months Deys	Hours Min. 8	Date of Birth (Month, Day, Yea 1 - 1 8 - 1	9. Birthp	place (Stete or Foreign NNSYLVANI
	/land		10a. State 10b. County 10c. City, Tow	m or Location			1	Od. Inside City Limits
	Man Feb	tor	MARYLAND BALTO. CO.					1 ☐ Yes 2 ☐ No
	h the	Director	10e. Street end Number	10f. Zip Code		10g. C	Citizen of Whet Cour	
	th wit		8928 HINTON AVENUE	212	19	22	USA	
020	a 1 and 2 should be filed within 72 hours efter deeth with the Maryland Health end Mental hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Experient court be incitited at	by Funerai	11. Manital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☒ No		y Yes or No- en, etc.)	14. Race - Americ Bleck, White, Specify:	
Maryland 21215-0020	within 72 ho lene. than "natur ne Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupe (Give kind of work done di life. DO NOT use retired)	tion uring most of working		Kind of Business/Ind	
D	Hyg ther ont, I	Be C	17. Fether's Name (First, Middle, Last)		18. Mother's Name (F			
an	fental ked o	ToB	JOHN YUCKA		MAGDALEN	F 7FS70	7Y7FWSK	Δ
any	2 should end Men is marke sumatic		19a. Informent's Neme/Relationship (Type, Print) 19b	. Meiling Address (Street e				
	and 2 saith e 27 is er fra		MRS. MARCELLA YUCKA 89	928 HINTON	AVE. BAL	TO. MD.	21219	
Baltimore,	ges 1 a it of Hea if Nem or othe		20a. Method of Disposition t\☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 20b. Plece of cemere	f Disposition (Neme of ry, cremetory or other place	b)	Dete 20c. I	Location - City or To	wn, Stete
Ē	Pages ment of ant: If its ury or o			STANISLAUS	CEM. 1-	31 BAL	TO. MD.	21224
Salt	permit. Pag Department Important: I any Injury o		21 Signature of Funerel Service Licensee	KACZOROWS	S of Eacility	AL HOME		
ш	202 # 9	(Marles To Xacsprowski	1201 DUND				222
	Physician /Medical Examiner		Pert1. Enter the disease, or complications that ceused the death. Do shock, or heert feilure. List only one of unless on each line. Immediate Ceuse (Final disease or condition resulting in death)	iA	, such as cardiac or r	espiretory errest,		Approximate Intervel Between Onset end Deeth
		ie.		consequence of):		4		
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68760,	ysicii	Medical	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e	consequence of):				
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Box	eath cer attendir I for use	an/l	d			· · · · · · · · · · · · · · · · · · ·	1	
0	the at	sic	Part II. Other significent conditions contributing to deeth but not resulting in	n the underlying cause give	n in Pert I.	23b. Did tobacc	o use contribute to	the cause of deeth?
P.O.	ed by detac	by Physician/	RESTRICTIVE CARDIOMYOPATI	ty. HYPET	2TEN SION	1 Tyes	2□ No 3 Prot	babiy 4 🗆 Unknown
Division of Vital Records,	law requires that the death ce es been signed by the attendii o 2 should be detached for use	Completed by	NOW-INSULIN DEPENDENT DIABET			24e. Wes en eut performed?	eve	ere eutopsy findings eileble prior to mpletion of ceuse deeth?
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ta	defan: The certificate irector, pag	Be	25. Wes case referred to medical exeminer?		26. Plece of Death (C	Check only one)		
<u>></u>	Physic this ce	2	1 ☐ Yes No Hospital: 10 Inpatient 2 ☐ ER/Ou	utpetient 3 DOA Othe	r: 4 Nursing Home	5 Residence	6 ☐Other (Specify	у)
sion	Attending Physician: The largest. ctor: After this certificate he to the funeral director, page	cation:	1t⊠Natural 5 □ Pending (Month, Dey Yeer) 1 2 □ Accident Investigation	Time of 28c. Injury 1 □ Y	et 280 ? 'es 2 □ No	d. Describe how inj	ury occurred	
DIV	5 4 8 5	Gertif	4 ☐ Homicide determined 25e. Place of injury - At nome, is building, etc. (Specify)			City or Town, Ste		
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			> Steer MO	97	7009	J7	TNUARY	28,1998
-	0×1		30. Name end eddress of person who completed cause of deeth (Item 23e)	(Type, Print) HSTERN AVE	0.0			21224
	w		SAADIA ALIZAT, MD 4940 EA 31. Dete filed (Month, Day, Year) 32. Dete filed (Month, Day, Year)	ISTERN MUSI	NUE, BA	LTIMOR	e, contice	TLAND

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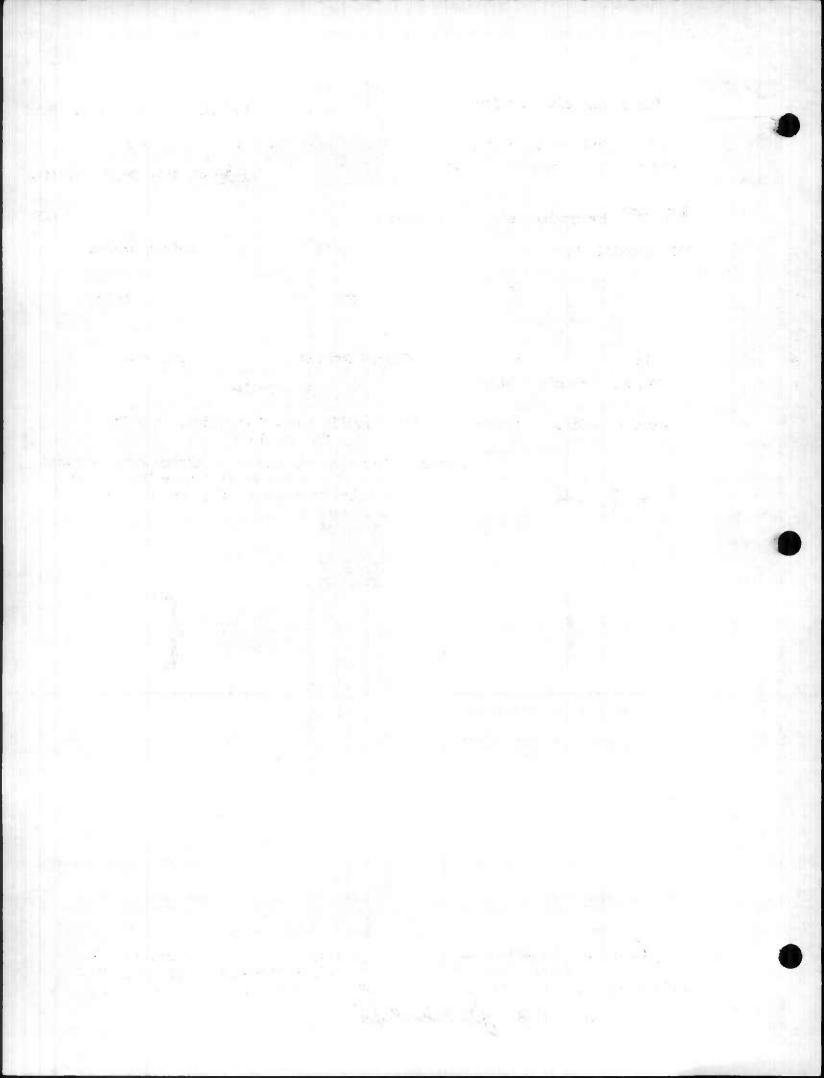
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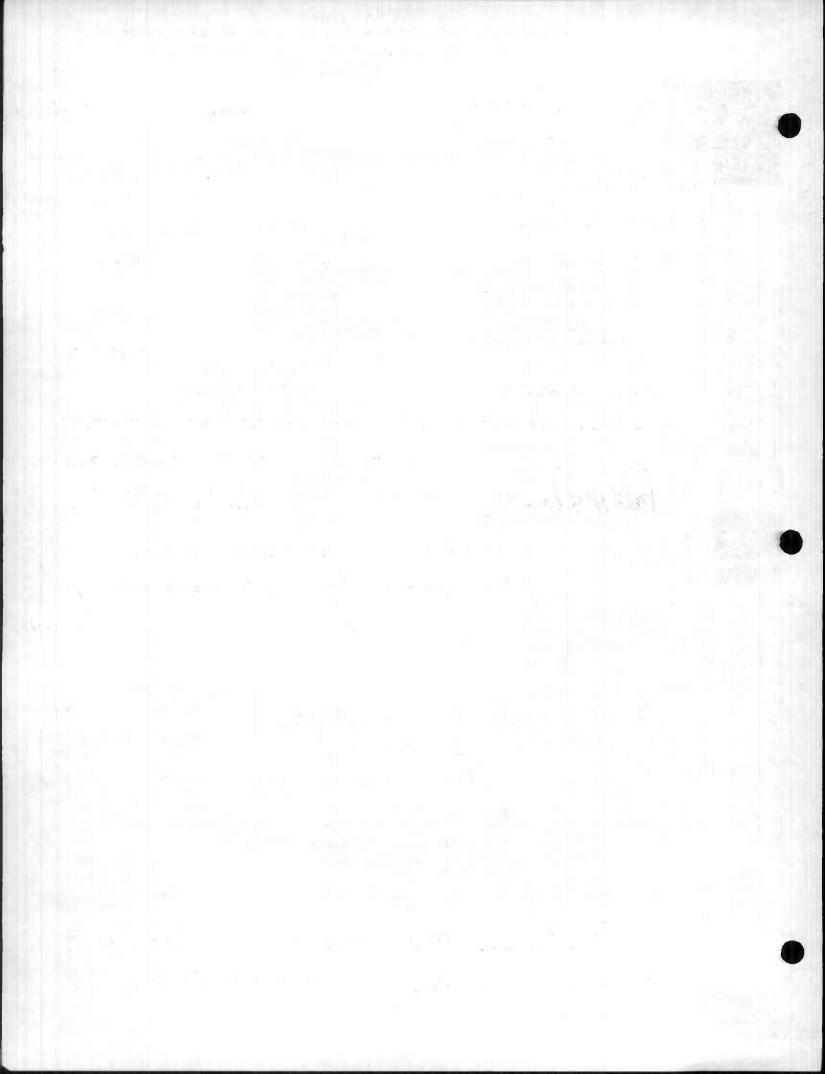
State of Maryland / Department of Health and Mental Hygiene 9 8 02478 Certificate of Death

Physic	ian	1. Decedant's Nama (First, Middla, L Billy Franci					2. Data of D Month	eath Day	Yaar	3. Tima of Death
/Medi	ical	4a. Facility Nama (If not institution, gi				4b. City, Town, o	JANUA:		998	10:15 P.M
Exami	ner									
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with the Maryler a or 28a-f show	rect	10e. Street and Number	George 5	Tare	10f. Zip Cod	A		10g. Citizan of	What Cou	
h with	Funeral Director	3110 Danville Roa	ad			613		United		
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21215-0020 d within 72 hours efter death with the Maryland glene. In than "natural", or Hems 23a or 28a-f show in the Maryland and the mast be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ XXS 2 □ No If Yas, Giva Yaar or Datas:		1 ☐ Yas 2√		arto riioan, atc.)		ick, Whita, by: Wh:	
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yland ould be file Mentel Hyg	Be C	Heywerd France						a, Maldan Sumar	na)	
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2 - T 5 5		20a. Method of Disposition	20b. I		Disposition (Nama of cramatory or other			20c. Location		
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Baltimore, pemit. Pages 1 er Depertment of Hea Important: If Item; any Injury or other		21. Signatura of Funaral Sarvice Lice		yıdı		drass of Facility				
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Physician		STOOK, O' Haat Tallula. List O'll	ona causa on aacir iiia.						-	Intarval Batween Onset and Death
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ox 68760, certificate be execu ding physician and use as the burial-tra	cian/Medical	resulting in death) Last	Dua to (c	or as a co	nsequance of):					
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		Part li. Other significant conditions	contributing to death but not ras	ulting in t	ha undarlying causa	given in Part I.	23b. Di	I tobacco use co	intribute t	to the cause of death?
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Bec e lew	npi								of	ompletion of cause death?
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of Vital Records, Physician: The lew requires this certificate has been signeral director, page 2 should be	Be	25. Was casa referred to medical axaminar?	Hospital: 35			28. Place of D	eath (Check only	ona)		
Phys rat di	- To	1 ☐ Yas 2 ☒ No 27. Mannar of Death	1. Inpatient 2	ER/Outp 28b. Tir	atient SLI DOA	4 LI Nursing		how injury occur		(y)
ding ding	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident invastigation	28a. Dete of injury (Month, Day Year)	Inji		njury at Vork? □ Yas 2 □ No	Zou. Describe	now injury occur	160	
Division of or attending Petter death. Director: After the funers of the funers	fica	3 Sulcida 6 Could not t	28a. Piace of Injury - At h	oma, fam			28f. Location	(Street and Numi	ber or Run	al Routa Number,
Die sele	Certification:	4 Homicida datamined	building, atc. (Specif	y)			City or To	own, Stata)		
DIVISION To the Hespital or Attend within 24 hours efter death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledga, o	deeth occurred at the or Invastigetion, in m	time, deta and plac y opinion, death oc	ce, and dua to the curred at tha time	a ceuse(s) end m , data and place,	annar as s and dua t	itated. o the causa(s)
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hysicia	n	ROBERT			TDONG				Month	Day	98	3. Time of Death
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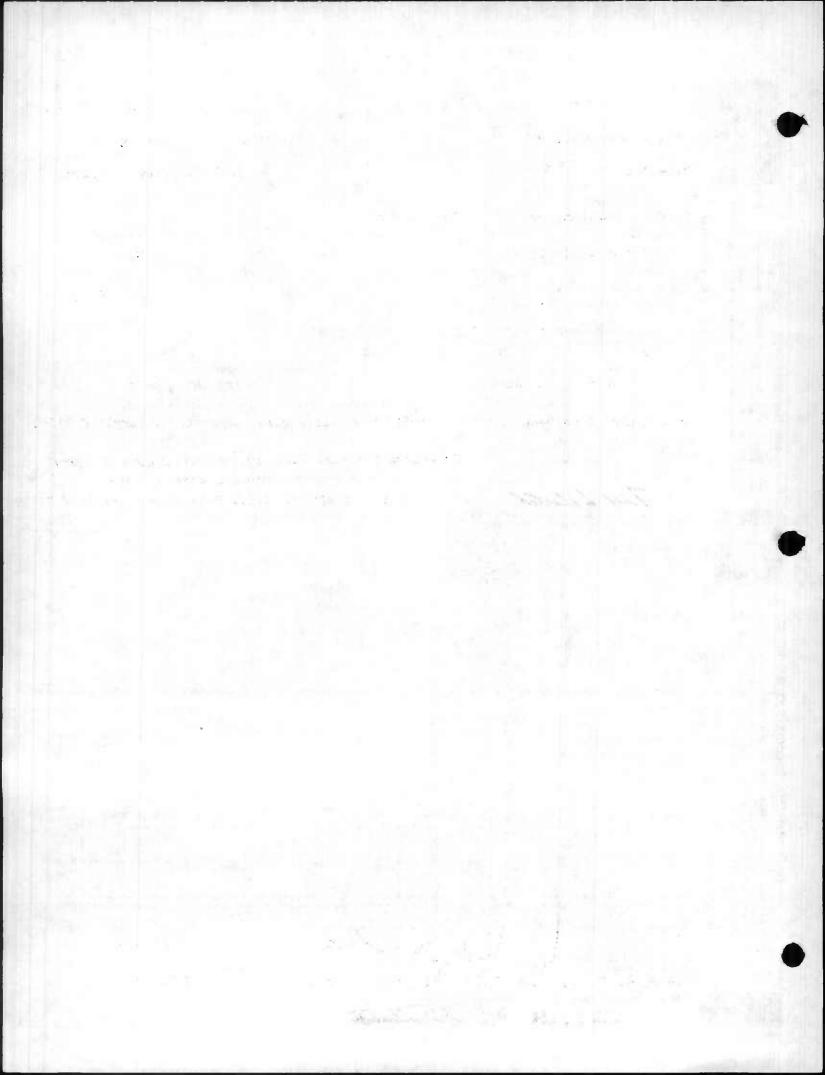
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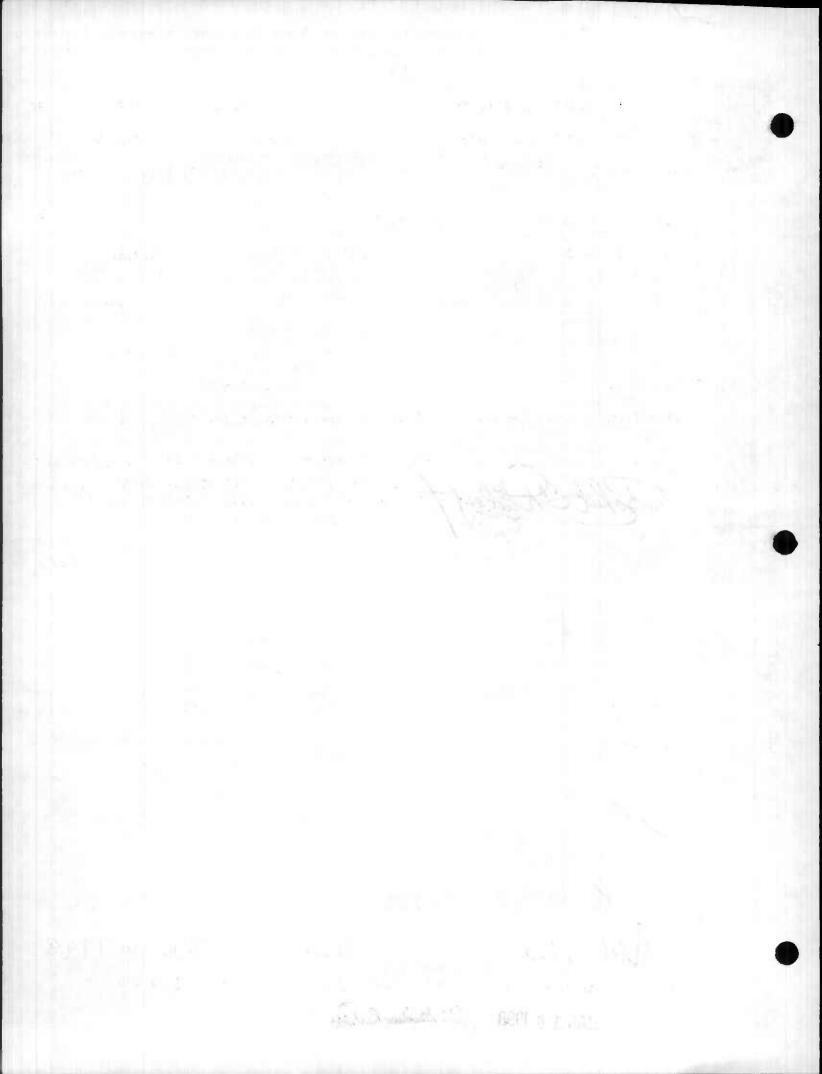
State of Maryland / Department of Health and Mental Hygiene 8 12 48 8

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12 sh h and h sm rs m	Ė	19a. Informant's Name/Relationship Mrs. Althea Rase/						ural Routa Numbar		te, Zip Coda) ryland 2174	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** Month 5:00 pm EARLEL. ARNOLD 98 DN 06 /Medical 4a. Facility Nama (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9701 MED CENTER DAROCKVILLE SHADY GROVE NURSING MONTBOMERY If Under 1 Yeer | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthdey) 8. Data of Birth (Month, Day, Year) Birthplace (Steta or Foreign Country) **Funeral** 1€ M 2□ F Director Nov 22 1926 Maryland 216-22-0549 Usual Residence of Decedar with the Maryland 10e. Stete 10c. City, Town or Location permit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examiner must be nothed at once. 10d. Insida City Limits MD Montgomery Dickerson 1 Yas 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizan of What Country? 18519 Wasche Road 20842 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 11. Maritel Stetus Wes Decedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indian. Bleck, White, etc. 1 ⊠ Yas 2 □ No If Yas, Give Yeer or Datas: WW II 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: white Ď 3 ☐ Widowad 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elamantery/Secondary (0-12) College (1-4or 5+) MD. Chief of maintenance NdL. Far.
18. Mother's Nama (First, Middla, Meidan Sumeme) Nat. Park & Planning 17. Fathar's Nama (First, Middla, Last) Jack Arnold 0 Mabel McMahon 19a. Intormant's Name/Ralationship (Type, Pnint) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) Ellen V. Arnold 18519 Wasche Rd. wife Dickerson, MD 20842 20b. Piece of Disposition (Name of cematary, cramatory or other piece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cremetion 3 Ramoval from State 4 □ Donation 5 □ Othar (Specify) Resthaven 1/9/98 Frederick, MD 21. Signature of Funerel Sarvice Licensee 22. Name end Address of Facility Hilton Funeral Home M 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart tallure. List only one cause on each line. Approximata Interval Between Onset and Death Physician Immedieta Causa (Final disaasa or condition rasulting in daath) /Medicai METASTATIC LUNG CANCER 4 MONTHS Examiner Dua to (or as a consequence of) Examiner physician and the burial-transit law requires that the death certificate be axecuted Sequantially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Disaasa or Injury that initiated avents resulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical Dua to (or es e consequance of): as esu. for signed by the a d be datached f Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed paga 2 certificata has 1□ Yas 2 No 1 □ Yas 2 □ No I or Attending Physician: after death. Director: After this certifica funaral director, 25. Was casa ratarred to medical axaminar? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Deta of injury (Month, Day Year) 27. Menner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding invastigation 1 Natural 1 Yas 2 No 2 Accident tha 6 Could not be datarmined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Plece of Injury - At homa, farm, straat, tactory, office bullding, atc. (Specify) filled in by 4 Homicida 24 hours a 1 Certifying Physician: To the bast of my knowledga, daath occurred at tha tima, deta end place, and dua to tha causa(s) and mannar as stated.

2 Medicat Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) end mannar stated. 29a. Cartifiar Medicai complataly (Check only one) To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

Hagger

Joseph Hag 31. Date tilled (Month, Day, Year)

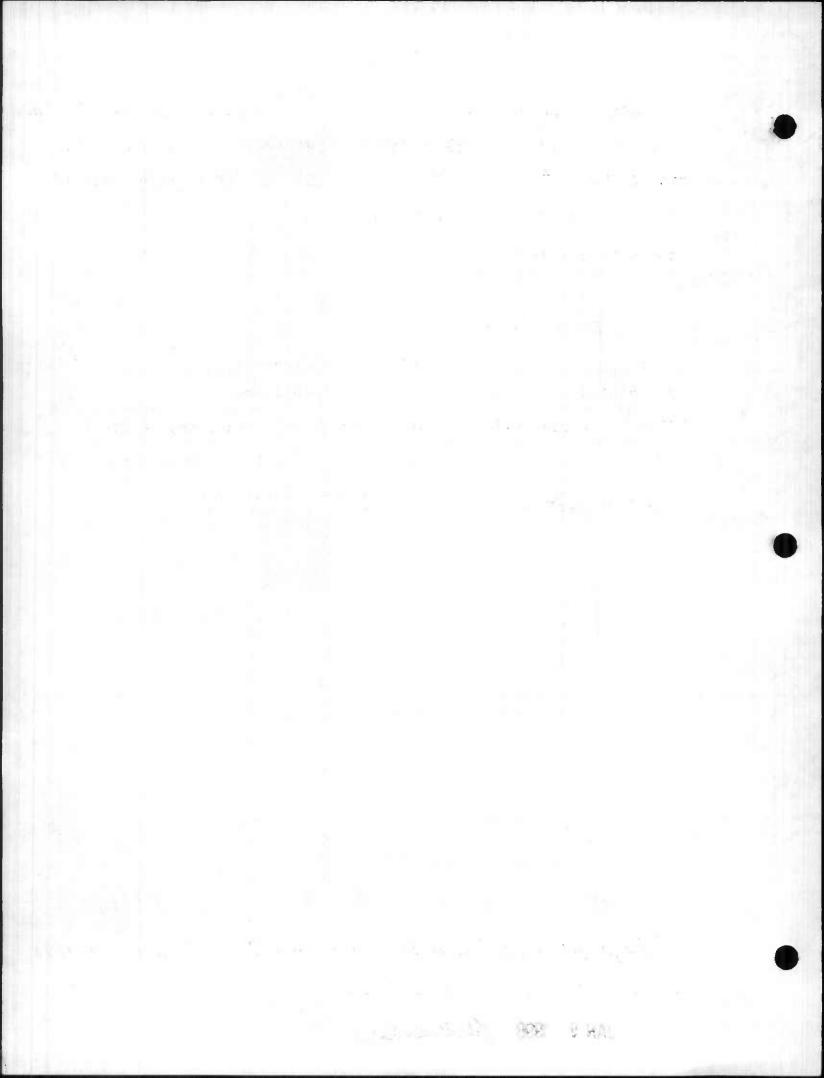
30. Name and address of person who completed causa of death (Item 23a) (Type, Print)



32. Ragistrer's Signetura

9707 med. Center

Drive #300 R'Ville 20850



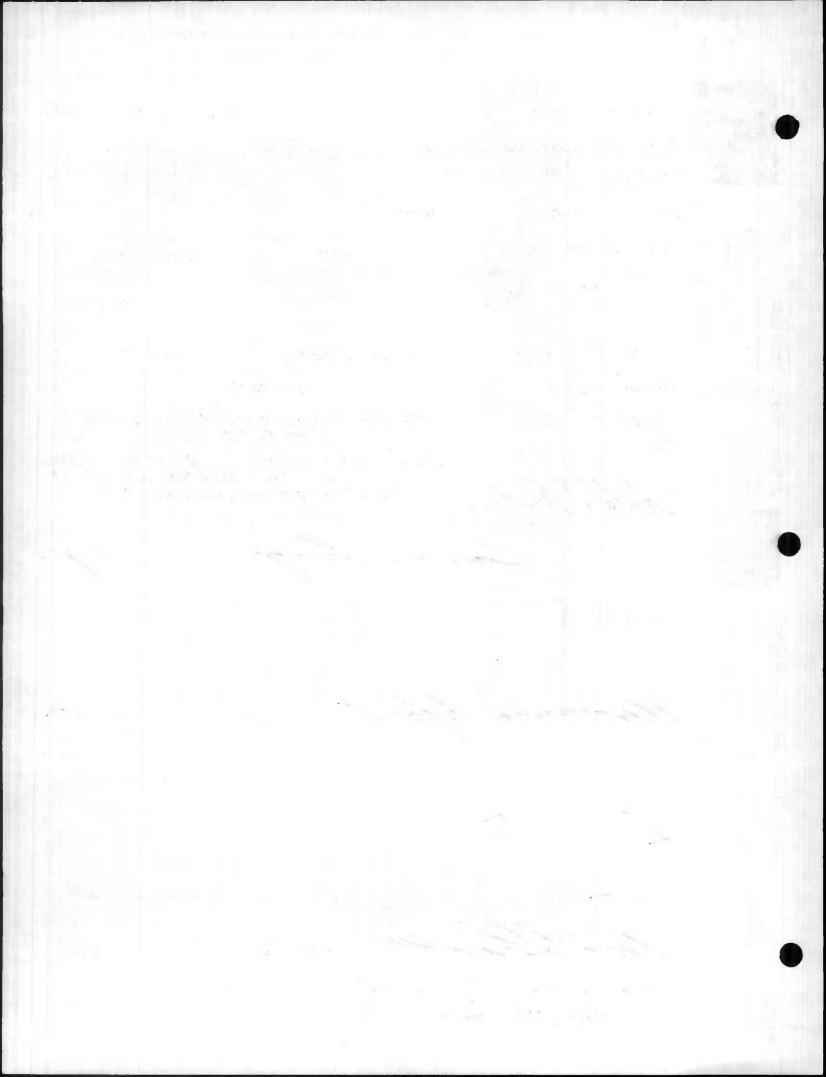
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1, Decedent's Nama (First, Middla, Last) 2. Data of Deeth 3. Tima of Deeth **Physician** Month 23:45 Peter 18, Bulka 1998 /Medical Jan 4e. Facility Nama (If not institution, giva street end numbar) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Center Clinton If Under 24 Hrs. Prince George If Undar 1 Yaar 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** M 2□ F Days Hours Yrs. Director 138-07-9593 June 21, 1916 New Jersey Usual Rasidance of Decedant death with the Maryland 10a. Stata 10h. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examinar must be notified at Charles MD Waldorf 1 Yas 2 TAN Director 10e. Streat and Number 2603 Mirkwood 10f. Zip Code 10g. Ciflzan of What Country? Court 20601 United States Funeral 12. Was Dacedanf Ever in U,S. Armed Forcas? 1 XX es 2 □ No If Yas, Giva Year or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. 11. Maritel Status parmit. Pagas 1 and 2 should be filed within 72 hours aftar t Department of Haaith and Mental Hygiana. Important: If Item 27 is marked other than "natural", or ther any injury or other traumatic event, the Medical Examin 1 Navar Married Married Baltimore, Maryland 21215-0020 1 Yas 2 XXo Specify: Specify: White Completed by 3 ☐ Widowad 4 ☐ Divorced 16a. Decedant's Usual Occupetion (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 U.S.A.F Military U.S.A.F. 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middla, Maidan Sumama) Be Michael Bulka Anna Bunak 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Routa Numbar, City or Town, Stete, Zip Coda) 8605 Captains House Road, Waldorf, MD 20603 William Henry Bulka 20b. Place of Disposition (Nama of cematary, cramatory or other place) Jan 23, 1998 20a. Mathod of Disposition

1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Maryland Veterans Cemetery Cheltenham, Maryland 22. Name and Addrass of Facilitee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735 23a. Part1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta Infervel Batwaan Onset and Deeth **Physician** /Medical Immediata Ceusa (Final disaase or condition rasulting in daath) Examiner Due to (or as a consequence of) Examiner sician and burial-transit Sequantially list conditions, if any, leading to immadiata ceuse. Enfar Undarlying Cause (Disaasa or injury thet initiated evants rasulting in daath) Lasf Dua to (or as a consequence of) P.O. Box 68760. attanding physician for usa as tha buna Physician/Medical Dua to (or as a consequence of): 88 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably Division of Vital Records. 9 24b. Were eutopsy findings evallabla prior fo complation of cause of daath? 24a. Was an autopsy performed? Completed peen has 2 No 1 □ Yes 2 □ No cartificata To the Hospital or Attending Physician: within 24 hours after death.

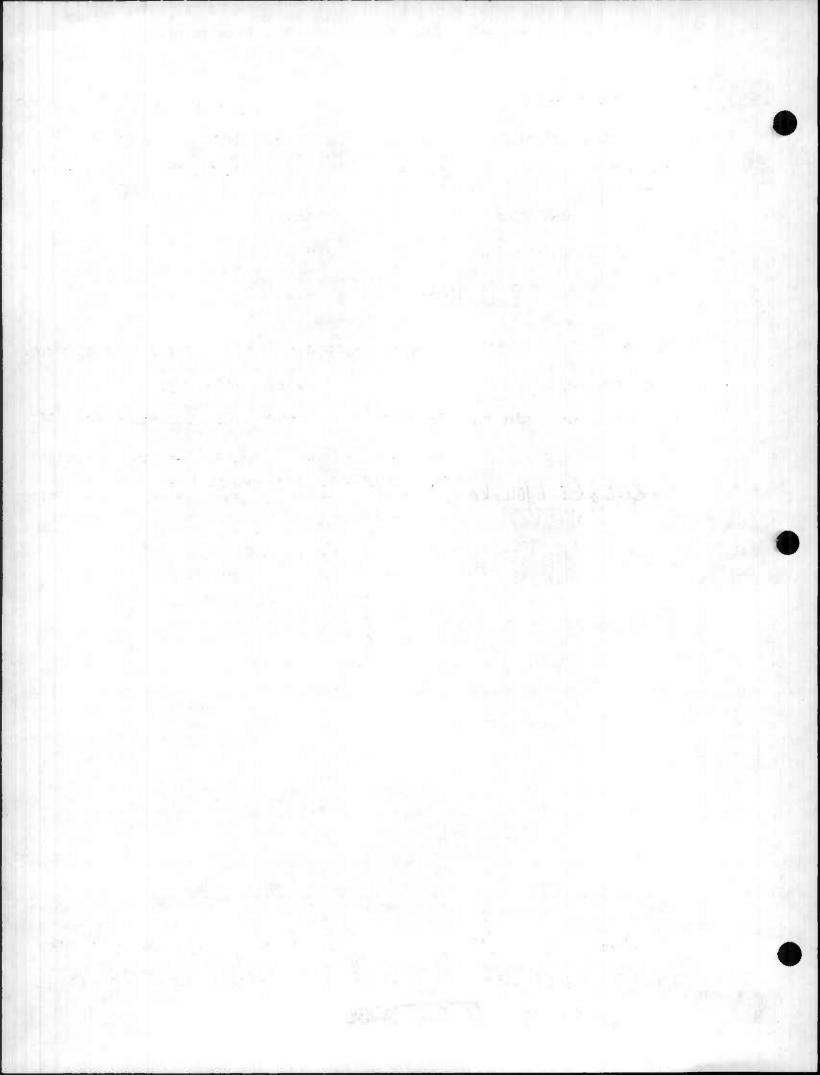
To the Funeral Director: After this certific complately filled in by the funeral director, 25. Was cesa raferred to medicel axaminer? Be 26. Placa of Death (Chack only ona) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) P 1 Yas 2 ER/Outpatient 3 DOA 2 Inpatiant 27. Manner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred Data of Injury (Month, Day Year) Natural 2 Accident 5 Pending investigation 1 ☐ Yas 2 ☐ No 3 ☐ Suicida 6 Could not ba 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 Homicida Certifying Physicien: To tha best of my knowladge, death occurred at tha time, date and piece, and dua to tha cause(s) and menner as steted.

2 Medical Examiner: On the best of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stetad. edical 29a. Cartifian 29b. Signature and little of certifier 29c. Licensa numbar 29d. Data signad (Month, Day, Year) 30. Name and eddrass of person who completed cause of death (Item 23a) (Type, Print) 9131 Piscataway Rd. Clinton, Md. 20735 Rene E. Grace M.D. 32. Registre's Signatura 31. Date filed (Month, Day, Year) State Registrar



State of Maryland / Department of Health and Mental Hygiene 8 02484

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th with th 23a or 28 unit be no	Funeral Director	10e. Street and Numbar 13301 Little Ant	ietam Road	ì	10f.	Zip Code	21742		10g. Citizen of \	Whet Country? USA
filed within 72 hours efter death with the Maryland Hygiene. ther than "natural", or items 23s or 28s-f show ent, the Medical Examiner must be notified at	by	11. Maritel Status 1 □ Navar Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedan Armed Forces 1 Ayes 2 If Yes, Give Year or Detes:			ecedent of I specify Cub s 2 XNo	Hispenic Origin? (en, Mexican, Pue Specify:	Specify Yes or Norto Ricen, etc.)		e - Americen Indian, ck, White, etc. White
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CA do to the	То	19e. Informent's Name/Relationship Kathleen Cooper					end Number or F	Rurel Route Num	ber, City or Town, Hagersto	
ite ite		20e. Method of Disposition 1		ceme	of Disposition (itery, cremetory) t Haven	or other ple		Dete Jan. 22		City or Town, Steta
permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Dos	Younk	0			Fiery			Maryland 2174
Physician /Medical Examiner	ner	Immediate Cause (Final disaese or condition resulting in death)	a. 5 M. A	Dua to (or es	e U (AV of):	2/200	A, briv	shogen	Intervel Between Onset end Death
ertificate be axecuted ing physician end e as the bunaf-trensit	/Medical Examiner	Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events	b. Due to (or es e consequence of): c							
eath certificate be axecuted ettending physician end for use as the bunal-trensit		that initieted events resulting in deeth) Last								
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es thet the death c igned by the ettend be detached for us	Certification: To Be Completed by Physician/	Total agrincan conducts	ontributing to death but not resulting In the underlying ceuse given In Pert I.				\ a*		ntribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown	
aw requires to been so									s en eutopsy formed?	24b. Were eutopsy findings eveileble prior to completion of cause of death?
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Physician: The this certificate ral director, pag		25. Wes cese referred to medical examiner?	Hospitel:			04		eth (Check only	опе)	
shys this al di		1 ☐ Yas 2 ☐ No 27. Manner of Death	1 ☐ Inpati			DOA Ott	4 LI Nursing		sidence 6 Oth	
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer		28a. Dete of Injury 28b. Time of 19 28c. Injury at Work? 2 Accident investigation 3 Suicide 4 Homloide 4 Homloide 28b. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)						28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number City or Town, Stete)		
To the Hospital within 24 hours a To the Funeral Completely filled	edical Ce	29a. Certifier (Check only one) 1 Certifying Pl	nyelclen: To the best miner: On the basis o end manner/st	f examinetion e	ge, deeth occurr end/or investigat	red et the til	me, dete end plea opinion, death occ	e, end due to the surred et tha time	e ceuse(s) end me	onner es steted. end due to the ceuse(s)
To the within 2 To the comple	Mec	29b. Signature end title of certifier	Dely M) .		29c Licens	111	3		d (Month, Dey, Year)
		30. Neme end eddress of person who	completed ceuse of a	leeth (Item 23e	(Type, Print)	5100	L CAN	RS Re	DAZ H	AGERTALIA 1707
Sta	te	31. Dete filed (Month, Day, Year)	32. Regist	ar's Signature				1		, 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 5:35 pm Maud Hook Bowman 18 1998 January 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Homewood Retirement Center Williamsport Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) March 1, 1901 9. Birthplece (State or Foreign Country)
Virginia 7. Age (In yrs. last birthday) 10 M 201 Deys 96 Yrs. 230-72-3844 Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Washington Williamsport 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 16505 Virginia Avenue 21795 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Race - American Indien, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Married White 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 11 Housewife Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Albert L. Hook Lelia Humphries 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Eleanor H. Phillips/Sister 15 Taylor Street Staunton, Virginia 24401 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Thornrose Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 1-21-98 Staunton, Virginia 22. Name and Address of Facility
Osborne Funeral Home 21. Signature of Funeral Service License 425 S. Conococheague St. Williamsport, MD 21795 23a. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heef fature. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final diseese or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieled events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es quence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

2

Affor Attending

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To the Hos within 24 h To the Fun completely

Physician

/Medical

Examiner

Director

Funeral

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d other than "natural", or items 23s or 28s-1 show event, the Medical Examiner must be notified at

Important: If from 27 is merked other than any injury or other traumatic event, the Maconce.

Pages 1 and 2 should be nent of Health and Mental

21215-0020

Maryland

Physician/Medicai þ

3 Suicide

2 Completed Be Certification: To

Medicai

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Alleage 25. Was case referred to medical examiner? 1 Yes 21-No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth

26. Place of Deeth (Check only one)

24b. Were eutopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy performed?

2ÚN 1 Yes

Other: 4 Natising Home 5 Residence 8 Other (Specify)

28c. Injury et Work? 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Haturel 1 Tes 2 Accident

6 Could not be 4 | Homicide

28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

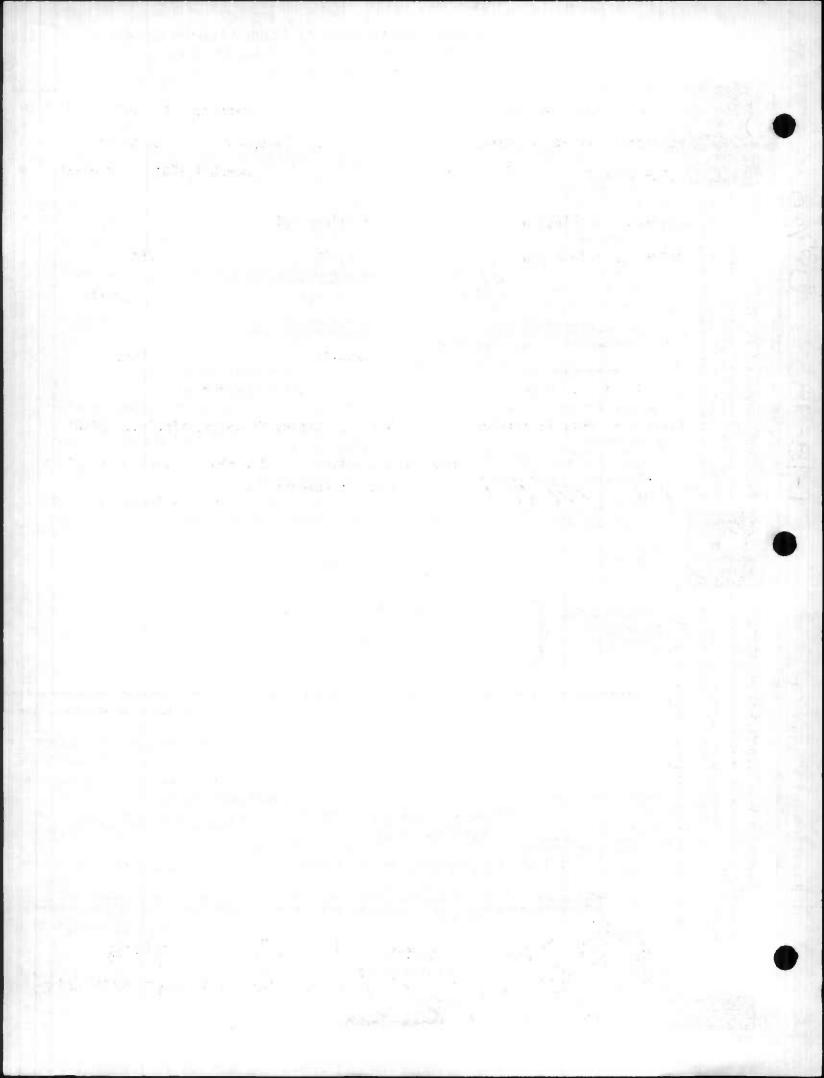
1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signatury 29c. License number 29d. Date signed (Mgnth, Dey, Year) D)(CA

eted cause of deeth (tem 23a) (Type, Print)

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State Registrar

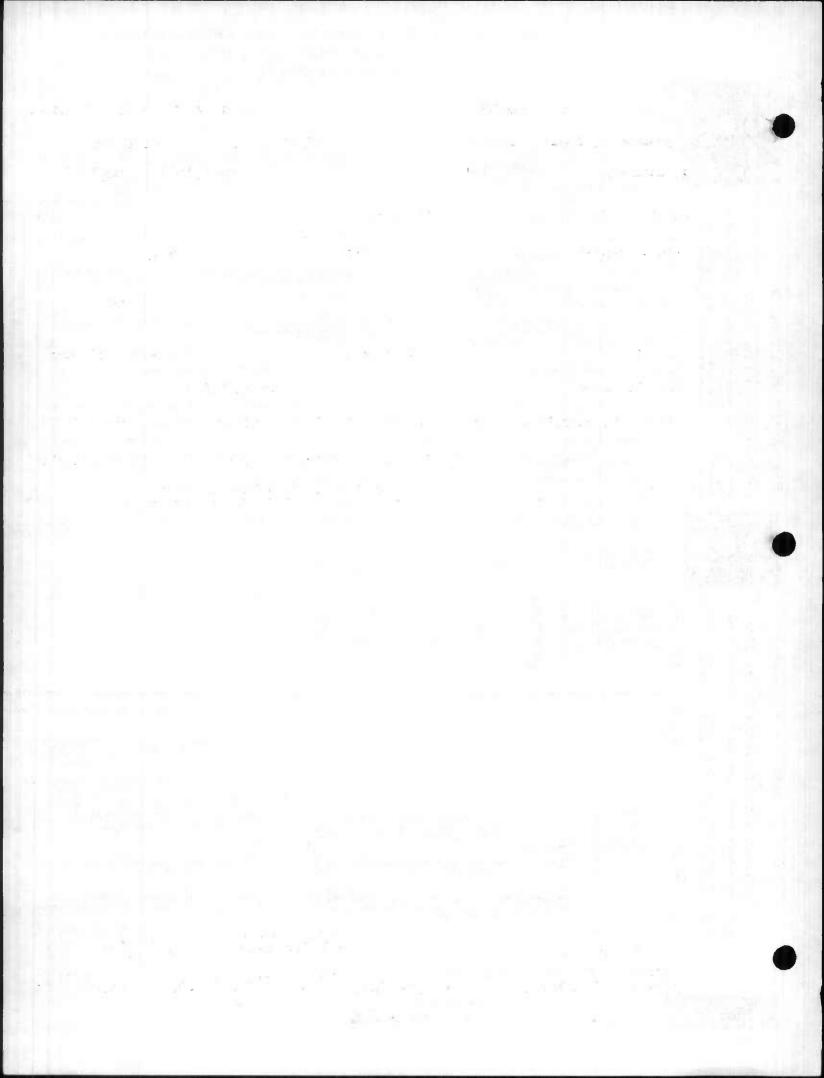


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death JAW . 17. 3. Time of Death **Physician** Dev Katherine Elizabeth Braidy and /Medical 4e. Fecility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Colton Villa Nursing Home Hagerstown Washington 5. Social Sacurity Number If Undar 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) June 5, 1904 9. Birthplece (State or Foreign Country) Mary land 6. Sax 7. Age (In yrs. last birthday) **Funeral** 1 M 2X F Months Deys 93 Yrs. June Director 215-14-2470 Usual Residence of Deceden death with the Maryland 10a. Stata 10b. County 10c, City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 DYes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 750 Dual Highway 21740 USA Funeral 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Biack, White, etc. 11. Marital Status permit. Pagas 1 and 2 should be filed within 72 hours aftar to Popartment of Haalih and Merital Hygiene. Important: if item 27 is marked other than "natural; or ite any injury or other traumatic event, in a Magnaticanine 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ZNo Specify: White þ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usuei Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 0 Housewife Home 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maidan Surname) Be Percy Chaney Ellen 2 Sadie Cline 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 625 W. Woodlane Rd. Westampton, NJ Frances E. Braidy/Daughter 08060 20b. Plece of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Dete 1 ☒ Buriel 2 ☐ Crametion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Mt. View Cemetery 1-20-98 Sharpsburg, Maryland 22. Name and Address of Facility
Osborne Funeral Home 21. Signeture of Funeral Service Licensel 425 S. Conococheague St. Williamsport, MD 21795 23a. Pert1. Enter the dispese, or complications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Examiner sician and burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated avants resulting in deeth) Lest Due to (or as a consequence of): physician s the burial P.O. Box 68760, Physician/Medicai Due to (or es a consequance of): 88 esn ed by the atter datached for u Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be datac 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. p 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en autopsy performed? paga 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medical examiner? Be 28. Piece of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 27. Menner of Death 28a. Deta of Injury (Month, Day Year) Certification: 28b. Time of 28d. Daacribe how injury occurred 28c. Injury at Work? al or Attending P s aftar death. I Director: Aftar Aftar 1 Nature 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 8 Could not be determined 3 Suicide 28f. Location (Straet and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral D completaly filled i edical 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(a) end manner es ateted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature and the of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and addrass of perach completed cause of deeth (Item 23e) (Type, Print 1. 492/1 31. Dete filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Viola Grace January 1998 7:55A.M. /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood Retirement Center Williamsport Washington 8. Date of Birth
(Month, Day, Year)
June 5, 1893 If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplece (Steta or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** 1□M 20 F Days Hours 104 Yrs. Director 219-36-4083 Maryland Usual Residence of Dacedani 10a. Stete 10b. County 10c. City. Town or Location 10d. Insida City Limits 28a-f ahow traumatic event, the Medical Examiner must be notified at Maryland Washington Williamsport Director 1 ☐ Yas 212 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 16505 Virginia Avenue 21795 Нета 23а U.S.A. Funeral 12. Wes Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indien, Bleck, Whita, atc. should be filed within 72 hours after and Mental Hygiene. marked other than "natural", or ite 1 ☐ Yas 2 ☐XNo If Yas, Giva Yaar or Dates: 1 ☐ Navar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 XNo Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elamantary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked other any Injury or other traumatic event pages. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Melden Surname) John B. Swope Hester A. Kline 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mildred M. Powell/Daughter 14632 National Pike Clear Spring, Maryland 21722 20b. Placa of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State St. Paul's Cemetery Jan. 20,1998 Clear Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signetura of Funerel Service Licensee 22. Nama end Addrass of Facility Douglas A. Fiery Funeral Home rough A 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 23e. Part1. Enter the disease, or complications that gausad the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, abock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset end Death **Physician** /Medical sove Syndrone Immediate Cause (Fine disaasa or condition rasulting in daath) Examiner that the death certificate be executed Sequentially list conditions, if any, laading to Immediata causa. Entar Undarfying Cause (Disaasa or Injury that initiated evants rasulting in death) Last pue Dua to (or as a consequence of): attending physician e for use as the buriel-Box 68760. Physician/Medical Dua to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1□ Yes 2 No 3 Probably 4 Unknown 0/1050/00515 signed I Records, ρ 24b. Wara autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed page 2 s 2 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 24 hours after deeth.
Funeral Director: After this certifica etely filled in by the funeral director, p 25. Was casa rafarred to medical axaminar? Be 26. Pleca of Death (Check only ona) 1 Yas 2 No Othar: 4√ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manpar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Sulcide 6 Could not be 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 24 hours 29a. Cartifian 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Hosp within 24 hou To the Fune completely fil Medical and mannar stated. 29b. Signeture end title of certified 29c. License number 29d. Date signed (Mooth, Dey, Year) omplated cause of death (Item 23a) (Type, Print) 31. Data filed (Month, Day, Year) 32. Ragis State JAN 2 0 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth 3. Time of Death Month Physician William . BLANK, SR. Franklin January 11, 1998 7:35 A.M. /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 2507 Monument Road Myersville Frederick If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number If Undar 1 Year 7. Age (In vrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** M 2□ F Months Deys 77 Yrs. Director 212-14-6266 March 9, 1920 Maryland Usual Rasidance of Dacedant the Manyland 10e State 10b. County show 10c City Town or Location 10d. Insida City Limits r than "natural", or Items 23a or 28a-f shorter Wadical Examiner Funt be not find at Maryland Frederick Frederick Director 1 Yas 2 No 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 5616 Bartonsville Road 21701 U.S.A. Funeral death 12. Wes Decedent Evar in U,S. Armed Forces? 14. Race - Amarican Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Ricen, atc.) filed within 72 hours after 1 DX as 2 No 1944 to If Yas, Give 1945 1 Navar Marriad 2 Married 21215-0020 1 ☐ Yas 25 No Specify: White by 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry ulth and Mental Hygiena. 27 is marked other than "r r treumstic event, tre Mer Elemantary/Secondary (0-12) Collega (1-4or 5+) 3rd Brick Layer Construction Company Baltimore, Maryland permit, Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked other any Injury or other traumatic event socie. 17. Fathar's Name (First Middle Last) 18. Mother's Nama (First, Middla, Maiden Sumame) Be William E. Blank Ethel M. Young 19a. Informant's Neme/Raiationship (Type, Pnint) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) William F. Blank, Jr./Son 2507 Mounument Road, Myersville, MD 21773 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete Mt. Olivet Cemetery 1 Burial 2 □ Cramation 3 □ Ramoval from Stata Jan. 14, 1998 Frederick, MD 21701 4 Donation 5 ☐ Othar (Spacify) 21. Signature of anaral Sarvice Licensaa 22. Name and Addrass of Facility Keeney & Basford Funeral Home 23e. Pentl. Enter the disease, or complications that course the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, Approximate shock, or heart failure. List only one cause on each line. Approximate Intarvai Batween Onset and Death **Physician** a audux /Medical Immediata Cause (Final disaase or condition rasulting in death) Examiner Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immediata ceuse. Enter Undarlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): 68760. Due to (or es e consequance of): 88 Box esn ò signed by the at d be datached for P.O. Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ should t 24b. Ware autopsy findings aveilable prior to Completed 24a. Was an autopsy complation of ceusa of daath? page 2 s has 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital or Attending Physician: director, 25. Was case rafarred to medical Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Assidence 8 Othar (Specify) 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 5 Pending invastigation 4 hours after dear. 1-BNatural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not ba 3 Suicida 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stata) 28e. Piaca of Injury - At homa, ferm, straat, factory, office building, etc. (Specify) 4 Homleida To the Hospital o within 24 hours af To the Funeral D completaly filled the critifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Moorn Dayr Year) 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print)

M.D., 700 Montclair Ave., Frederick, Md. 21701

32. Registrar's Signatura

Jalin Davidson Rarlatte

State

Registrar

Robert S. Hughes,

31. Data filed (Month, Day, Year)

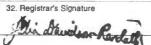
State of Maryland / Department of Health and Mental Hygieriè Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month Year Thornton Lawrence Boyd January 11, 1998 /Medical 1:30 P.M. 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 611 6th Street Frederick Brunswick

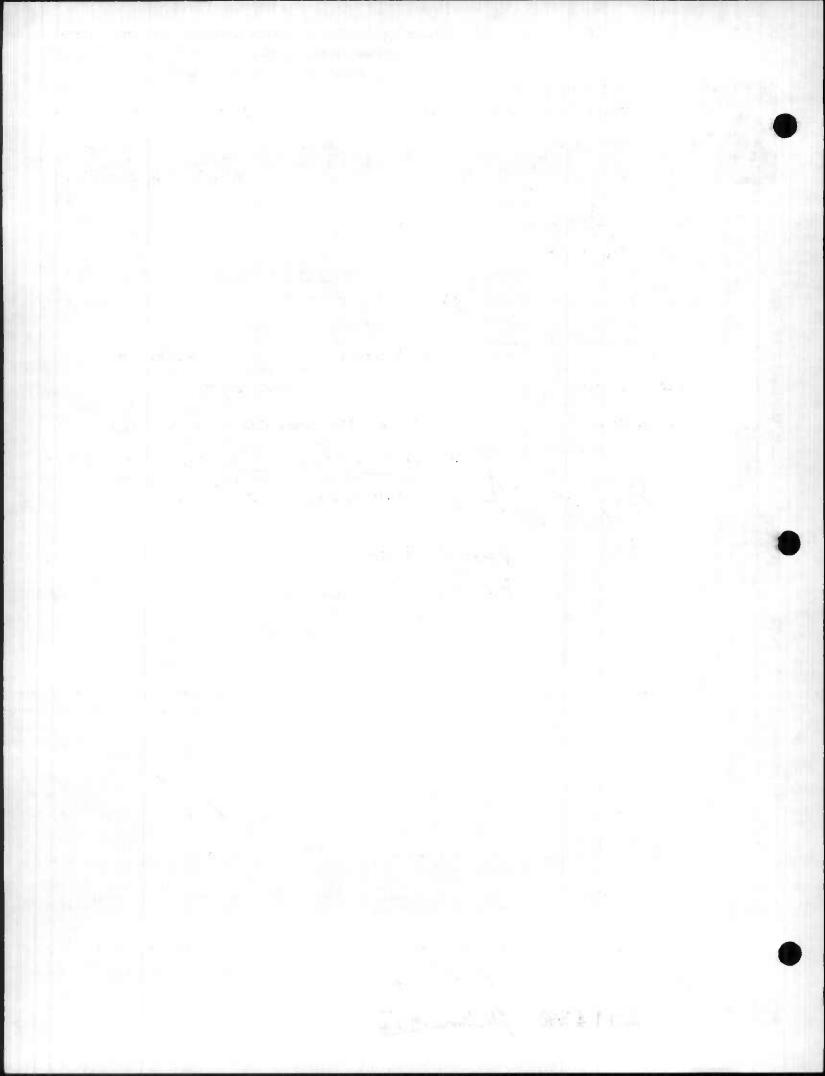
If Undar 1 Yaar | If Undar 24 Hrs. | 5. Social Security Number 6. Sax 7. Age (In yrs. lest birthday) 8. Data of Birth (Month, Dey, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1⊠M 2□ F Yrs. Director 172-26-3802 63 Feb. 1, 1934 Pennsylvania Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Yas 2□ No Directo Maryland Frederick Brunswick 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 611 6th Street 21716 U. S. A. death 11. Marital Status 12. Was Decadant Ever In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If fes, Giva 1954 Yeer or Detes: 1957 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Aq Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withir Department of Health and Mantal Hygiane. Important: If Item 27 is marked other than any injury or other traumetic event. The Mantal Injury or other traumetic event. Elamantary/Secondary (0-12) College (1-4or 5+) Task Leader Maxima Corp. 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Harry J. Boyd Alfreda McBrien 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Lois W. Boyd - wife 611 6th St., Brunswick, Maryland 21716 20b. Place of Disposition (Name of cematary, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) agerstown, Maryland Hagerstown Crematory med Junerel Service Light 22. Name end Address of Fecility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland rt1. Enter the disease, or complications that caused to beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical immedlete Ceuse (Final disaase or condition rasulting in death) **Examiner** Examiner The law requires that the death certificata be executed burial-transit Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted avents resulting in deeth) Last and P.O. Box 68760. attending physician Physician/Medical the Due to (or as a consequence of): θS Po Pert ii. Other aignificent conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? 2 1 Yes 2 No 3 Probably 4 Unknown s been signed be should be dete Records, by 24e. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed page 2 cartificate has 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To this 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) To the Hospital or Attending PI within 24 hours effer death.
To the Funeral Director: After the completely filled in by the funera 28b. Time of 28d. Describe how injury occurred Aftar t Certification: 28c. Injury et Work? 5 Pending Invastigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not ba 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 1 Certifying Phyeicien: To the best of my knowledge, deeth occurred et the time, data and place, end due to the ceuse(s) end menner es steted. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. 29b. Signature end title of certifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) D41866 January 12, 1998 30. Neme end eddress of person who completed cause of deeth (item 23e) (Type, Print) FREDERICK, mD 21701 D3 801 TOLL HOUSE AVE KANAN HUDHUD, MD

State Registrar

JAN 1 4 1998

31. Date filed (Month, Dey, Year)





State of Maryland / Department of Health and Mental Hygiene

						Cei	tificate (of Death	n	R	eg. No.	0 6.	- 750			
			Decedent's Name (First, Middle, L	ast)						2. Date of Dee			3. Time of Death			
	Physician	_	James Davi	ď	Bagge	att				Month JANUARY	Day 10, 19	Year	1541PM			
	/Medical	40	Facility Name (If not institution, gi			ELL		4b. City,		ation of Death	4c. County		TJ-TITI			
	Examiner	10.0														
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	Funeral			Sex 7. 1 ☑ M 2 □ F		lest birthdey) Yrs.		ays Hours	s Min.	8. Date of Birth (Month, Day		9. Birthpi	lace (Stata or Foreign try)			
	Director	-	52-98-9130	X	42	115.				Sept 8,	1955	Georg	ia			
	Pu »		ual Residence of Decedent a. State 10b. County		1400 Ci	ty, Town or Lo	antion					14	0d. inside City Limits			
	anyle show		a, State Too. County		100. 01	ly, TOWITOT LC	Cation						1			
	o Me	Maryland Frederick Mt. Airy									1 ☐ Yes 2 No					
	72 hours effer death with the Meryland natural; or items 23s or 28s-f show yeal Examiner must be notified at steed by Funeral Director	10	e. Street and Number				10f. Zip Co	de		1	0g. Citizen of V	Vhat Coun	try?			
	13a c		759 Woodville Re	nad			21771				United	Stat	.00			
	r items 23	11	Maritel Status	12. Was Deced	ent Ever in U	,S. 13. 1		of Hispenic (Origin? (Spec	cify Yes or No-	14. Rec	e - Americ	an Indian,			
	ter ter	3	1 Never Married 2 Married	Armed Forc	es?		If Yes, specify	Cuban, Mexic	can, Puerto P	Rican, etc.)	Blac	ck, White,	etc.			
20	ors of		3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 If Yes, Give Year or Date	06:		1 ☐ Yes 2	No Specia	ty:		Specify	· wh	nite			
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a	2 sho end is me		a. Informent's Name/Relationship	(Type, Print)		19b. Meili	ng Address (St	reet and Num	ber or Rural	Routa Numbe	r, City or Town,	Stata, Zip	Coda)			
	C = 0 -	M	ari L. Baggett	/ wife		5759	Woodvi	Te Ros	ad. Mt	. Airy,	MD 2	1771				
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Á	Physician /Medical	Im	mediate Cause (Finel	.1	1	0 .1	1 1	. 1								
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0	ith. Aft e fur e fur e		1 □ Natural 5 □ Pending investigation	. 1	98	154	M		No	subject	buyels	T, h	11 04			
Division	rs or Attending P rs efter death. In Director: After led in by the funer: Certification:		3 ☐ Suicide 6 ☐ Could not	200. Flace O	I Injury - At h	ome, farm, st	eet, fectory, of	fice	2	8f. Location (S	treat and Numi	per or Rur	A Route Number,			
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	To To To Man	29	b. Signature and title of certifier	11	,		29c. Li	cense numbe	91	2	29d. Date signe	d (Month,	Day, Year)			
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		30	. Name and address of person who	completed cause	of/death (Ital	m 23e) (Tuno		C.M.E.			JANUARY		1998			
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JAN 1 4 1998

Jahr Davidson Radally

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3 Time of Deeth 2 Date of Deeth Margaret Christine BAKER January 10, 1998 10:45 P.M. 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Homewood Retirement Center Frederick Frederick | Honder 1 Year | Honder 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) | Dec • 28, 1912 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiece (Stete or Foreign Country) 1 M 2 X F Yrs. Maryland 213-24-7761 85 Usual Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location Maryland Frederick Frederick MTYes 2□No 10a. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 31 West Patrick Street 21701 U.S.A. 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specity: White Specify: 3 X Vidowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th Seamstress Clothing Manafacturing 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Hattie Christina Trittipoe Joseph William Cordell 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Michele McComas/Niece 113 Fairvield Drive, Baltimore, MD 21228 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 General 2 Cremation 3 Removel from State ReformedCemetery
4 Donetlon 5 Other (Specify) Jan. 15, 1998 Jefferson, Maryland 22. Neme end Address of Fecility Keeney & Basford Funeral Home M00021 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or shock, or heart feilure. List only one cause on each line. 106 East Church Street, Frederick, MD 21701
Approximet the mode of dying, such as cardiac or respiratory errest,
Approximet Approximete Intervel Between Onset and Deeth Immediate Cause (Finet disease or condition resulting in deeth) sentiremen Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet Initieted events resulting In deeth) Last Due to /or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uea contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28d. Describe how Injury occurred 1 Naturel 5 Pending Investigetion 1 Tyes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

ng physician and as the burief-transit the death certificate ba executed Box 68760. attending | P.O. 1 signed by the a Division of Vital Records, peen cartificate has funeral director Be al or Attending Physics after death.

I Diractor: After this cold in by the funeral directors. Certification: illed in by To the Hospital of within 24 hours at To the Funeral D complataly filled it

Physician

/Medical

Examiner

Director

Funeral

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Medical

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7 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Medical Examiner must be notified at

pemit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiana, Important: If itam 27 is marked other than "natural", or items 230 any Injury or other traumatic event, the Medical Experimental 2006.

Physician

/Medical

Examiner

3altimore, Maryland 21215-0020

with the Maryland

4 ☐ Homicide

29b. Signature end title of certifier

31. Date filed (Month, Dey, Year)

29a. Certifier

1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted.

2 Medical Examinar: On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted. 29c. License number 29d. Date signed (Month, Dey, Year)

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

, M.D., 300 West Ninth St., Frederick, MD 21701

State Registrar

Francis E. Becker,



Facility of 1907 & 1944.

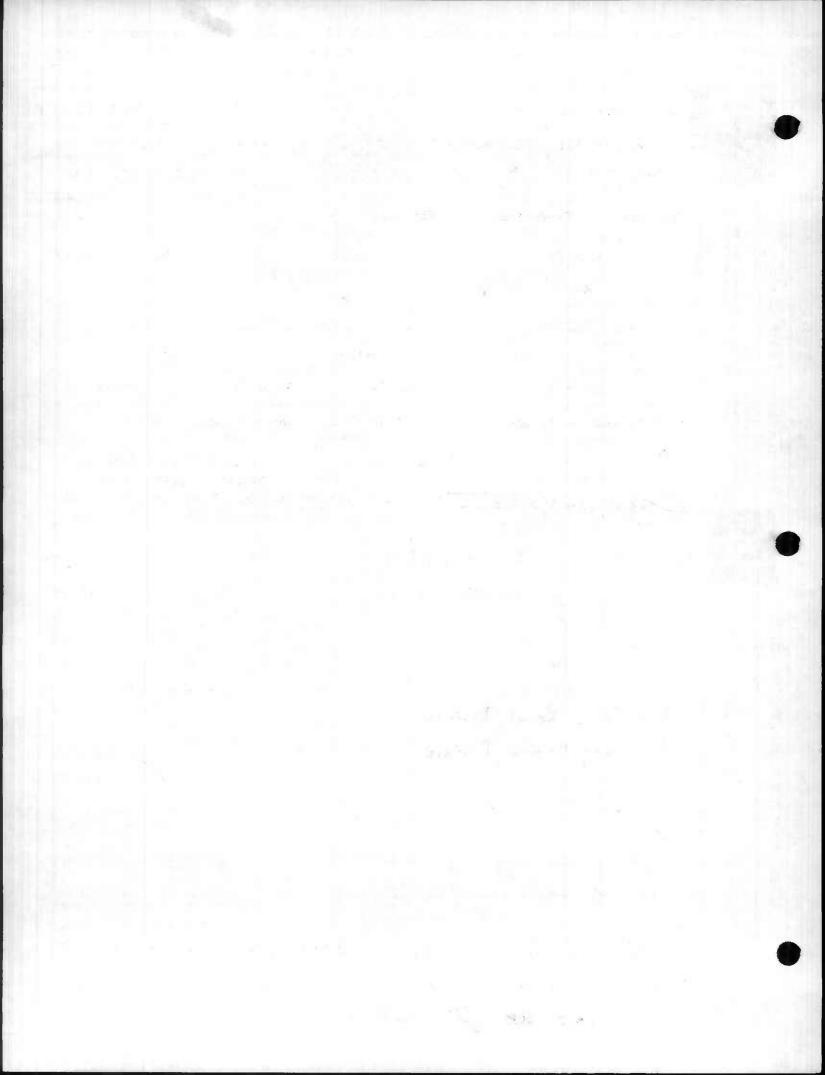
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Caro1 1998 Lee Beck January 11:30 PM /Medical 4a. Facility Nama (If not institution, give street end number) 4h City Town or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick if Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) Birthplaca (State or Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) **Funeral** 1□ M 20 F Days Hours Yrs. 580-80-8564 57 Director Nov. 26,1940 0klahoma Usual Rasidance of Decedant the Marylend permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any hjury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits Frederick Thurmont 1 Yas 2 No Maryland Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Coda United States 126 Water St. 21788 Funeral Was Decedant of Hispanic Origin? (Spacify Yas or No-II Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - American indien, Black, White, atc. 12. Was Decedant Evar in U,S. Armed Forces? 11. Maritai Status 1 ☐ Yas 20 No If Yas, Giva Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker own home 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Qualls Mildred 0scar Lee 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Carl L. Beck / husband 126 Water St./ Thurmont, Md. 20b. Place of Disposition (Name of cametery, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 □ Cramation 3 □ Ramoval Irom State Burial 2 Uramauon 5 Other (Specify) 1-12-98 Tylersville, Pa. Union Cemetery 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Md. 21702 sal ee the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiretory errest, heart takens. List only one cause on each line. Approximeta Intarvel Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition rasulting in death) Cardiomy pathy
Dua to (or as a consequence of): Examiner Examiner Mellit physician end the buriel-transit Sequantially list conditions, if eny, leading to immadiata ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Lest Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): for use es Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco usa contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown End Stage Renal Disease þ 24b. Wara autopsy lindings eveilable prior to complation of ceusa of death? 24a. Was an autopsy performed? Coronary Artery Diregie hes 2 No 1 ☐ Yas 2 ☐ No this certificate Hospital or Attending Physician: 24 hours after deeth. Funeral Director: After this certifica funeral director, 25. Was cesa referred to madicel axaminer?

1 Yas 2 No Be 26. Place of Daath (Chack only ona) Hospital: Othar: 4☐ Nursing Homa 5☐ Rasidance 8☐ Othar (Specify) 2 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 28e. Data of Injury (Month, Day Year) 27. Manper ol Death 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No Invastigation 2 Accident 6 Could not be detarmined To the Hospital or Atterwithin 24 hours after der To the Funeral Director completely filled in by the 3 ☐ Sulcida 28l. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Cartifiar Medical 29b. Signature and title of certifiar 29c. License number 29d. Dete signed (Month, Dey, Year) D47679 M.D. January 8, 1998 30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) , 201 Thomas Dunson Dr. Frederick, Hd Trancis Gregory Guillo 31. Data filad (Month, Day, Yaar) 32. Ragistrar's Signatura State Jalin Dhudson Randall

DHMH 16 Rev 6/95

Registrar

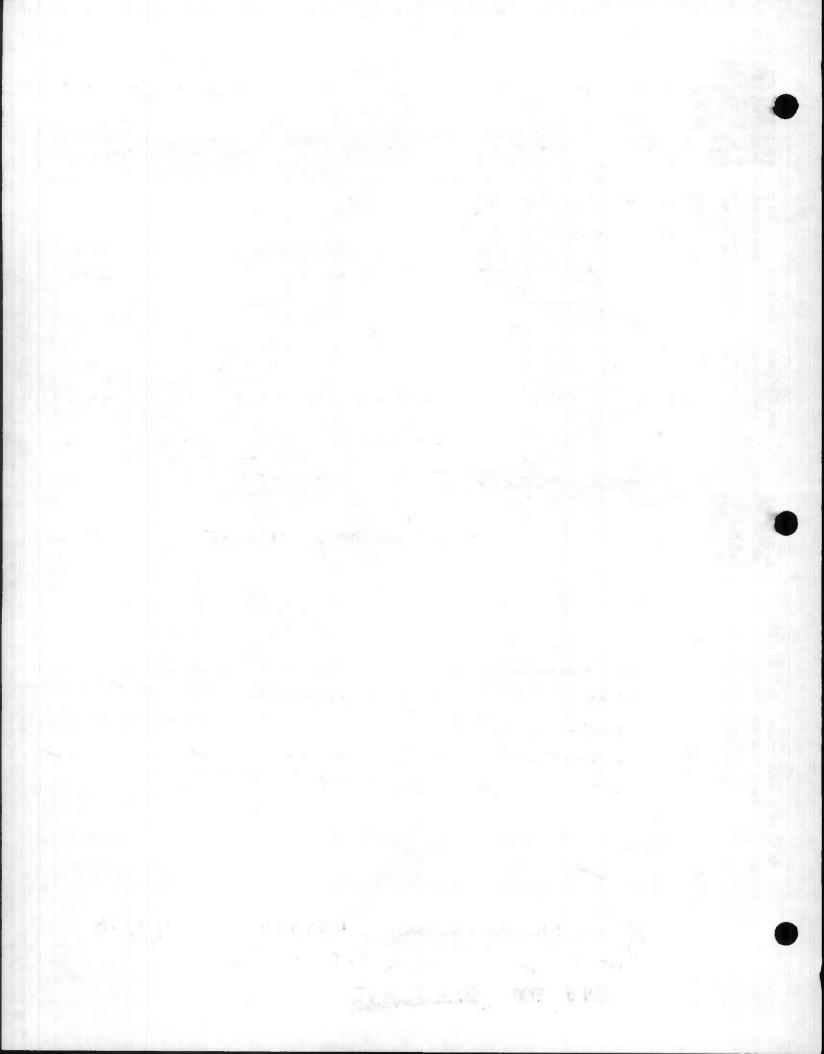


State of Maryland / Department of Health and Mental Hygiene Q

112493 Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Day **Physician** 10:11 a.m. Kenneth Lee Brown January 1998 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, giva straat and number) Examiner Frederick Memorial Hospital Frederick Frederick If Undar 1 Yaar If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stete or Foraign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** 1MM 20 F Months Days Hours Yrs. 216-34-4781 Director Aug. 16, 1938 West Virginia 59 Usuai Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 77 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Frederick Walkersville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8841 Whimsey Court 21793 U. S. A. Funeral death 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, atc. permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hygiena. Important: If Itam 27 is marked other than "natural; or iten any injury or other traumatic event, the Medical Eventuations. 1 Never Married Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Spacify only highest grede completed) Heating and College (1-4or 5+) Elementary/Secondary (0-12) Airconditioning Mechanic 18. Mothar's Name (First, Middla, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Goldie Lee Brown Bethel Viola Unger 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shirley Brown - Wife 8841 Whimsey Court, Walkersville, Maryland 20b. Place of Disposition (Neme of cemetery, crametory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cemetery 1-12=98 Walkersville, Md. 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funaral Service Licansee 1621 Opossumtown Pike, Frederick, Md. 21702 23a. Part . Part lergy Fifth the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, repent failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician Immadiata Causa (Final disease or condition resulting In deeth) /Medical CALDIORESpirator ARREST 30 MIN Examiner Due to (or as a consequence of): Examiner sician end buriei-transit requiras that the death certificate be exacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated avents resulting in death) Last Due to (or as a consequance of): Division of Vital Records, P.O. Box 68760, attending physician for usa as the burie Physician/Medical Due to (or as a consequence of): 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed by the page 2 should be datached 1 Yes 2 No 3 Probably 4 Unknown CODB Hyperupinema p 24b. Were autopsy findings available prior to 24a. Was an autopsy performad? ASCVD completion of cause of death? cartificate has TOBACCO ABUSE 1 Yes 2 □ No 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was case referred to medical Be 26. Plece of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Rasidenca 8 Othar (Specify) 1 Yas 2 No 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how Injury occurred 27. Menner of Death 1 Watural 5 Pending efter death. 1 ☐ Yas 2 ☐ No invastigation 2 Accident the 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner steted. edical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 29d. Date,signed (Month, Dey, Year) 29c. Licensa number 29b. Signature and fitle of certifier 98 D39444 udemen mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAUSHMANS trederick 110 LANC 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Jalia Davidson Revolate JAN 9 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death Month January Boyer 3:33 AM Betty Ruth 4a. Fecility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Undar 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplaca (Steta or Foraign Country) 8. Date of Birth (Month, Dey, Year) 1□M 2XF Yrs 217-16-2217 75 1922 Nov. 16, Maryland Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 Yes 2 No 10e. Street end Number 10f. Zip Coda 10g. Citlzan of What Counfry? 417 Columbus Avenue 21701 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yas, Giva 13. Wes Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Bleck, Whita, etc. 1K Nevar Married 2 ☐ Married 1 ☐ Yas 2 X No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Payroll Clerk Potomac Edison Company 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) William Edward Boyer, Sr. Emma Jane Derr 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Mildred Boyer/Sister-in-law 417 Columbus Avenue, Frederick, Maryland 21701 20b. Placa of Disposition (Nama of cematery, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 XBuriai 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 1/8/98 Mount Olivet Cemetery Frederick, Maryland ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Entar tha diseasa, or com-shock, or haart failure. List only the daeth. Do not anter the mode of dying, such as cardiac or respiratory errest, Approximate Intervel Batween Onset end Death ancor- Motastatic Immediata Cause (Final disaasa or condition resulting in death) Due to (or as a consaguance of) Sequantially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Disaasa or injury that inifiated events rasulting in death) Last Dua to (or as e consaguence of): Dua to (or es e consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Nos 2 No 3 Probably 4 ☐ Unknown 24b. Wara autopsy findings available prior fo completion of cause of death? Coronovy autory disease Penteraded Diodual Ulcer 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Wes case refarred to medical axaminar?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a Stata

Director

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Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic svent, it a Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after dea Depertment of Health and Mental Hygiena. Important: If Itam 27 is marked other than "natural". ~ invertion of the traumatic average to the page of

death with the Meryland

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Certification:

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Box 68760,

Division of Vital Records, P.O.

1 Yes 2 No

Hospital: Inpatient 2 ER/Outpatient 3 DOA 28a. Deta of Injury (Month, Day Year) 28h Time of 28c. injury at Work?

5 Panding invastigation 6 Could not be determined

28a. Placa of Injury - Af homa, farm, street, factory, offica building, atc. (Specify)

26. Pleca of Deeth (Check only ona)

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

🗠 Sertifying Phyaician: To tha bast of my knowledge, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as steted.

29a. Certifier (Check only one) 29b. Signatura and

27. Mannar of Deeth

Natural

2 Accident

3 Sulcida

4 - Homicida

2 Madical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner stated. 29c. License number 29d. Data signad (Month, Day, Yaar)

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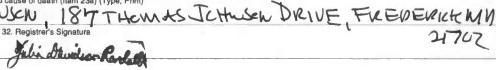
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State Registrar

31. Data filad (Month, Day,

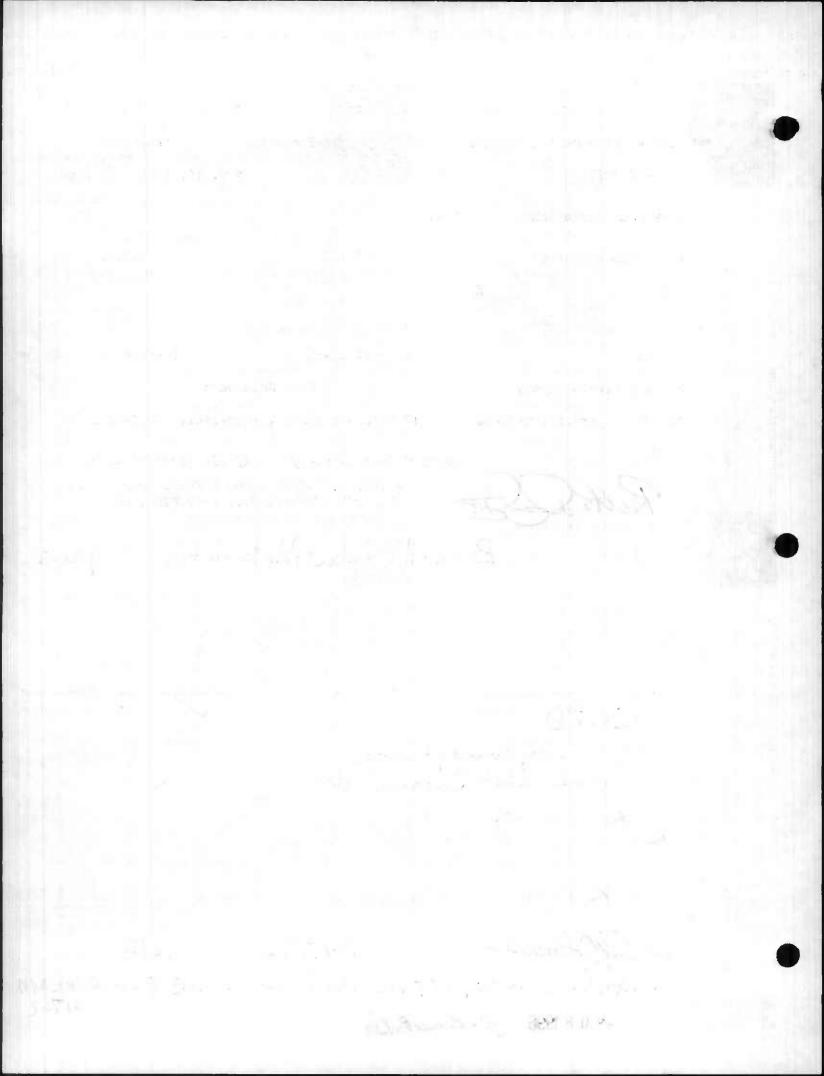


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State of Maryland / Department of Health and Mental Hygiene Q

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			on County	-					Hager			-	shi	ngton		
neral cotor		5. Social Security N 211-09-4 Usual Residence of	151	INM 2□ E	7. Aga (In yrs. 80	lest birthday) Yrs.	If Under Months		If Under Hours	Min	8. Date of Bir (Month, De April	10,19	17	9. Birthp Coun West	lece (State or try) Virgin	Foreign nia
A W		10a. State	10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside Cit	y Limits
notified at	tor	Maryland	Washingt	on	Hage	rstown	1								1 ☐ Yes	2] [] No
10 N	lirec	10e. Street end Nu	mbar				10f. Zip	Code				10g. Citiz	en of V	Whet Coun	try?	
Tan la	<u>a</u>	11203 Big	g Pool Ro	ad			21	711				U.S	S.A	•		
Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Navar Marr 3 ☑ Widowed	ried 2 Married	12. Was Daced Armed For 1 Yes If Yes, Give Year or De	2 ☑ No e		Was Deced If Yas, spec 1 ☐ Yes		lispenic Ori an, Mexicar Specify:		pecify Yas or No- Rican, etc.)		14. Race - American In Black, White, etc.		etc.	
	p		15. Decedent's Ed	ducetion		16e. Deced	dent's Usua	al Occup	etion			16b. Kin	nd of Bu	Whit		
other traumatic event, the Medical Exam	Completed	(Spec	cify only highast gra	de completed) College (1-	-4or 5±1	16e. Deced (Give life. L	kind of wo	rk done i se retired	du <i>ring</i> mos	t of work	ing					
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important: if item 27 is marked other than any injury or other traumatic event, the Moones.		4 Donetion	☐ Cremation 3 ☐ 5 ☐ Other (Specifunerel Service Licer	ý)	State	anktown	n Cem	eter	y Jar	ty	, 1998	Big	y Pc			nd
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29c. Licansa number

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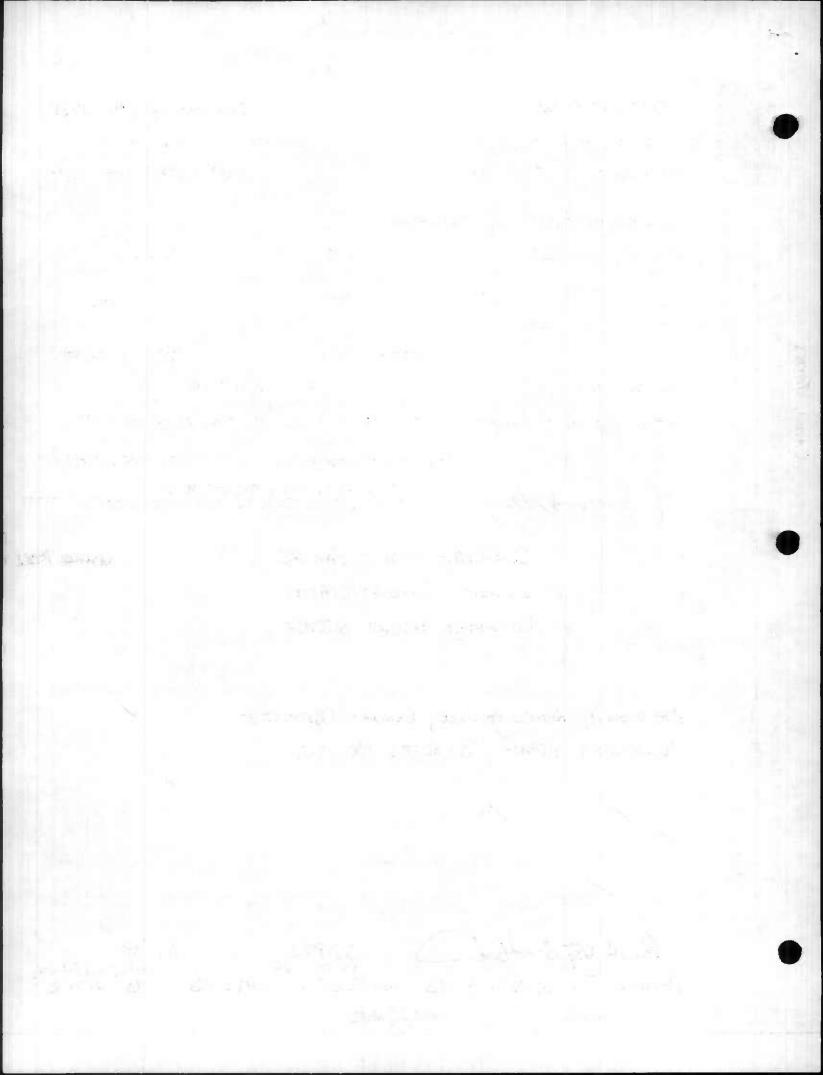
29d. Date signed (Month, Dey, Year)

1/14/98 HAGTERSTOWN, MS 21742

State Registrar 29b. Signature and title of certifier

PAMELA FOX 31. Date filed (Month, Day, Year)

JAN 1 5 1998

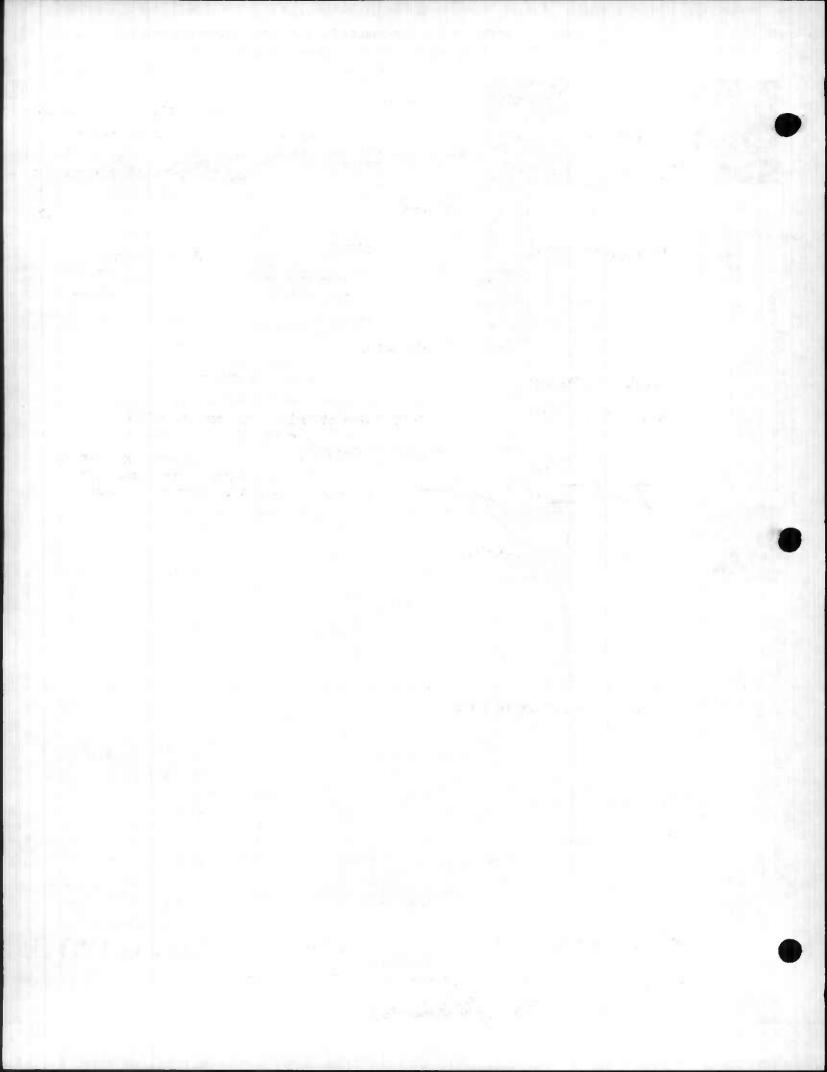


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 02496

						Cei	rtificate	of	Death			Reg.	No.	U	496
Physic /Medi	edical				Deanell					2. Dete of Deeth Month January		Day		3. Time of Deeth	
4a. Fecility Nema (If not institution, give street and number) 7817 Wynnwood Drive				nber)	4b. City, Town, or Lo Clinton										
Funeral Director		5. Sociel Security Number 213 40 8977 Usual Residence of Decedent	6. Sex 1 □ I	1 2 2 2 1 1	7. Aga <i>(In yrs.</i> 8		If Under 1 Months	1 Yeer Days	If Under Hours	24 Hrs. Min.	8. Dete of Information May 28				place (State or Foraign http) ington DC
or 28a-f show	tor	10a. Stete 10b. Cour MD P.	-		-	ty, Town or Lo inton	ocation							1	10d. Inside City Limits
23s or 28s	Funeral Director	10e. Street end Number 7817 Wynnwood	Drive	2			10f. Zip (What Cour	
or items uniner m	by	11. Marital Status 1 Never Married 2 M 3 X Widowed 4 Divorce	arried 12		21⁄22No e		S. 13. Was Dacedent of Hispenic Orlgln? (If Yes, specify Cuban, Mexican, Pue 1 □ Yas 2 □ No Specify:			gln? (Sp n, Puerto	ecify Yes or I Rican, etc.)	1	Bleck, White, e		can Indian,
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nd Mental Hygiene. marked other than umatic event, the M	To Be (17. Fathar's Name (First, Middle, Lest) Frank E.A. Felker							18. Mothe	_	e (First, Midd McCart		ien Sumer	me)	
Haalth end I em 27 is me other traume		19e. Informant's Name/Reletic Carl L. Deanel				7817	Wynnv	VOO(d Driv	7e, (el Routa Nun Clinto				Code)
Department of Haalth er Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 Burial 2 □ Cremetion 4 □ Donetion 5 □ Other		novel from S	State For	Place of Dispo cemetery, crar t Linc	oln Ce	eme:	tery			Br	entw	ood,	own, Stete Maryland
Department of months of mo										Funeral Home, Inc 6633 Old Road, Clinton, Md 20735					
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y the	Physician	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. Coronary Artery Disease											o the cause of death'		
s been sign 2 should be	Completed by			-							24e. We	es en ei rformed	utopsy ?	av	ere eutopsy findings ailable prior to impletion of cause deeth?
- 6		25. Was case referred to medi	cal						26 Place	of Deet	1 [Yes	2X No	1[☐ Yes 2☐ No
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ifter daath. Director: After this certific in by the funeral director,	ertification: To Be	1 Yes 2 14 to 27. Magner of Deeth 14 Neturel 5 Pen 2 Accident 3 Suicide 6 Cou	stigation	28e. Plece	of Injury h, Dey Year) of Injury - At h	Injury ome, farm, str	М	1 🗆	rk? ∣Yes 2⊡	No		(Street	t end Numi		el Route Number,
or death. octor: After this certific by tha funeral director,	0	1 Yes 2 140 27. Magner of Deeth All Neturel 5 Pen inve 2 Accident 3 Suicide 6 Cou 4 Homicide dete	stigation Id not ba imined	28e. Plece buildin	of Injury - At hig, etc. (Special best of my knows six of examina	ome, farm, str	M eet, fectory,	1 □ office	Yes 2	d placa,	28f. Location City or 7	own, Si	e(s) end m	ber or Rure	iteted.



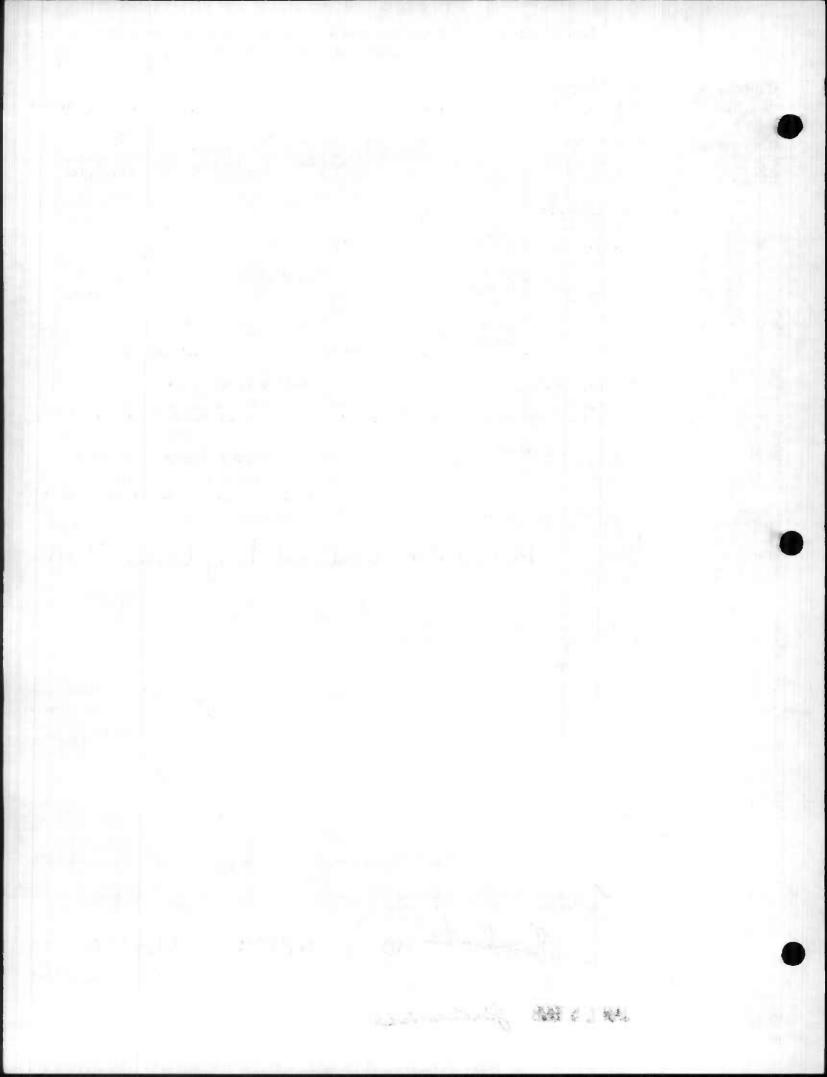
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death Dey 1998 **Physician** Month Yaar January 13, 12:30 Am Devilbiss Delores /Medical 4e. Fecility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daeth 4c. County of Death Examiner Thurmont Frederick 6005 Blue Mountain Road | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Yaer) | 9. Birthplaca (State of Country) | April 16, 1939 | Frederick 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthpiaca (Stata or Foreign **Funeral** 1□M 2□F 58 Yrs. 219-36-4610 Director Usual Rasidance of Dacedant death with the Maryland 10a. Stata 10b. Count 10c. City, Town or Location 10d. Inside City Limits worke 7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, the Medical Examiner must be notified at Frederick Maryland Thurmont 1 Yas 2 No Director 10f. Zip Coda 21788 10a, Street and Numba 10g. Citizan of What Country? 6005 Blue Mountain Road Funeral 12. Was Decedant Evar in U,S Armed Forcas? Wes Decedant of Hispenic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 end 2 should be filed within 72 hours after or Department of Health and Mental Hygione. Important: if Itam 27 is merked other than "natural", or then any Injury or other traumatic event. Bleck, White, etc. 1 Navar Marriad 2 1 Married 1 ☐ Yas 2€XNo If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 white 1 Yas 2 No Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education 16b. Kind of Businass/Industry (Specify only highest greda complated) Elementary/Secondary (0-12) College (1-4or 5+) Owner Operator Market Basket 17. Fether's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Pauline Edith Sweeny Charles Lee Weddle 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 6005 Blue Mountain Road, Thurmont, Maryland 21788 Robert Devilbiss - husband 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other piece) Data 20c. Location - City or Town, Stata 1 ☑ Buriai 2 ☐ Crametion 3 ☐ Removal from Stata Blue Ridge Cemetery 1-15-98 Thurmont, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Service Licensaa 22. Name end Addrass of Facility Stauffer Funeral Home 104 East Main St., Thurmont, Maryland aron 21788 au 23a. Pert1. Entar the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haer failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Small Cell lung Cancer immediete Ceusa (Final disaasa or condition rasulting in death) Examiner Examiner buriel-transit Sequantielly list conditions, if any, leading to immadiate causa. Entar Undarlying Causa (Disaasa or injury that initieted avants rasulting in death) Last and Due to (or as a consaguance of): ettanding physician for use es the buriel Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): been signed by the should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings aveileble prior to complation of ceuse of death? 24a. Was an eutopsy Completed page 2 has 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificat completaly filled in by the funeral director. 25. Was casa refarred to medicei Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 PResidence 1 Yes 2 No 10 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 6 ☐ Other (Specify) 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Death 28b. Tima of 28d. Dascribe how injury occurred Certification: 1 Naturei 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) Place of Injury - At homa, farm, street, fectory, office building, etc. (Spacify) 4 Homloide 1 (Certifying Physicien: To the best of my knowladga, daath occurred at the time, date end place, and dua to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifian Medical (Check only one) 29b. Signatura and titla of certifian 29c. Licansa numbar 29d. Date signed (Month, Dey, Year) 48184 501 W 7th Street Frederick MD 21701 30. Nama end address of person who completed causa of death (Itam 23a) (Type, Print) Elhamy ESKander

32. Registrar's Signatura

State Registrar 31. Deta filad (Morth, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

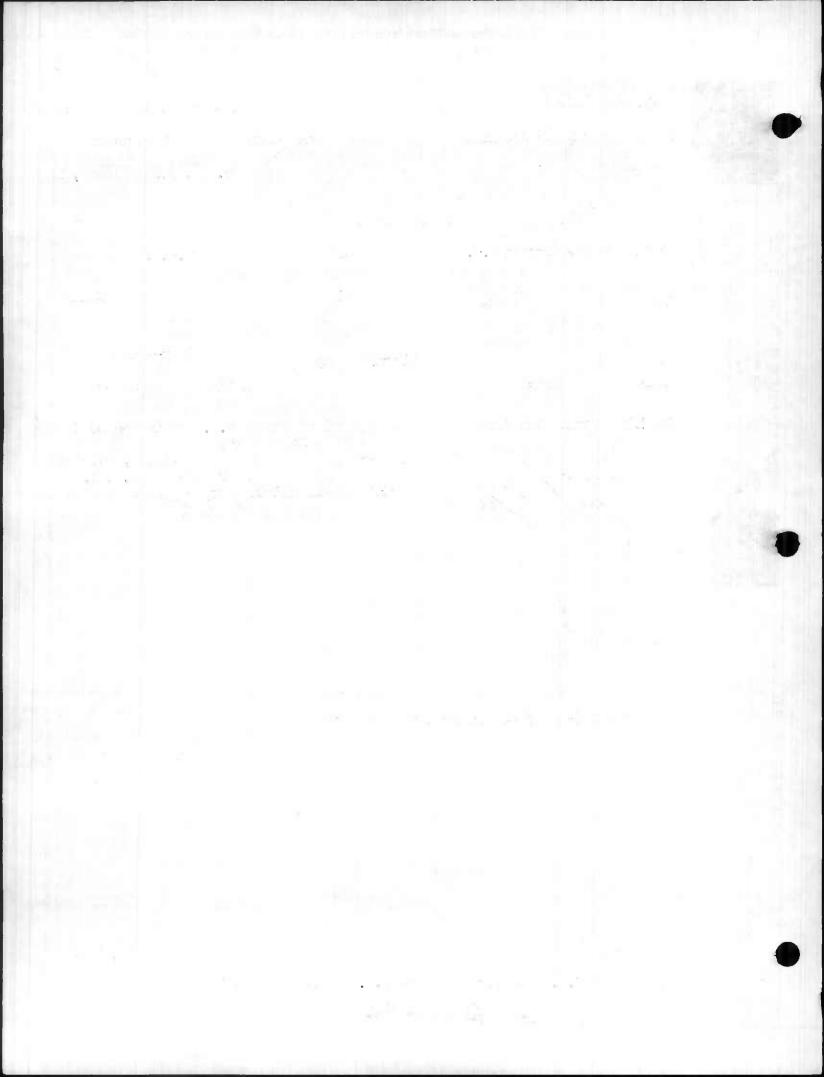
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time f th Day **Physician** Month 13, BERNICE BARBARA DEVILBISS Jan. 1998 9:20 M /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner Homewood Retirement Center Frederick Frederick 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) **Funeral** Birthplece (Stete or Foreign Country) 1□M 2\ F Deys Hours Ohio 220-52-9176 92 Yrs. Director 1905 Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Frederick Frederick 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 203 Brooklawn Apartments 21701 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours efter to Department of Health end Mental Hygiene. Important: If Itam 27 is marked other than "naturel", or item any injury or other traumatic event 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Teacher Board of Education 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Frank C. Ryan Caroline Faber 2 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Betty Sayler/Niece 30 W. Broadway, P.O. Box 506, Union Bridge MD 21791 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremetlon 3 ☐ Removal from State Smithsburg Crematory 4 Donetion 5 Other (Specific 1/14/98 Smithsburg, Maryland ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 e death. Do not enter the mode of dying, such es cardiac or respiretory errest, **Physician** /Medical Immediate Cause (Finel black with 6 mnh disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed physician end the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequença of) 0 Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? been signed by should be detact 1 Yes 20 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings evelleble prior to Completed 24e. Wes en eutopsy performed? completion of cause of deeth? certificate has page 2 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital i Hospital or Attending Physician: 24 hours efter death. I Funeral Director: After this certifica etely filled in by the funeral director, t Be 25. Wes cese referred to medical examiner? 26. Plece of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Buaturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide n 24 hours eff Funeral Di detely filled in 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 29a. Certifier within 24 hor To the Fune completely fil Medical 2 Medicel Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end manner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) A. Austin Pearre Jr., MD 300 West Ninth Street, Frederick, Maryland 21701 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signeture State Jalia Stevelson Rarlett

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene

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Physician		 Decedent's Neme (First, Middle, Last France 		70				2. Dete of De Month		Yeer	e of Deeth	
/Medical Examiner	ŀ	le. Fecility Neme (If not institution, given Manor Care Healt		7)			4b. City, Town, or Chevy Cha		1 4c. County	of Deeth	:50AM	
uneral	5	5. Social Security Number 6. S	ex 7. A			Under 1 Yea onths Dey	r If Under 24 Hr	s. 8. Date of Bir		gomery 9. Birthplece (State Country) Chicago,	le or Foreig	
>	-	Usuel Residence of Decedent		140.00	-							
r 28a-f show inothing at		N/A 10b. County N/A N/A			ty, Town or Locati					10d. Inside	City Limit es 2 □ N	
28a-1	5	IV/A 10e. Street end Number		wa	shington	DC 10f. Zip Code		T	10- 011		92 Z 🗆 IA	
s 23a or		3722 Harrison S				20015			U.S.A.			
Examples 23a or 28a-1 a Examples could be notified 1 by Funeral Director	1	1 Maritel Status 1 □ Never Married 2 □ Married Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 X Yes 2 ☐ If Yes, Give Yeer or Dates	No		Decedent of s, specify Cu	Hispenic Origin? (s ben, Mexicen, Puer Specify:	Specify Yes or No rto Rican, etc.)	Specify	e - American Indien, ck, White, etc. :: White		
nt the Medical Exercity, the Medical Exercity Completed by		15. Decedent's Ed (Specify only highest gre	ucetion de completed)		16e. Decedent	's Usuel Occi	upetion a during most of wo ed)	orkina	16b. Kind of B	usiness/Industry		
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27 is r trau			(Daughter	-)							015	
othe	2	Oa. Method of Disposition		20b. F	Place of Disposition	n (Neme of	$_{ece)}$ Januar	TZ Page	20c. Location -	ton DC 20 City or Town, State	015_	
y or		1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		e Cremato			1998	Clinot	n, Maryla	ba	
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ng physician and as the burial-transit Medical Examiner		Gequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury het initiated events esulting in deeth) Lest	r es e consequen									
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igned by the ettandi be detached for use by Physician/		Prostate Cancer; Congestive Heart Failure						10	Yes 2□ No	3 Probably 4	M) Unkno	
2 should								perio	en eutopsy rmed? N/A	24b. Were eutops eveilable pric completion o of deeth?		
pag. Cor								1 🗆	Yes 2□No	1 □ Yes 2	□ No	
director, page		25. Was cese referred to medical exeminer?	Hoenital:					eth (Check only o	one)			
5 8		1 ☐ Yes Z No 7. Manner of Deeth	Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
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		4 Homicide determined	28e. Plece of in building, e	ijury - At hi tc. (Specif	ome, tarm, street,	factory, office		28f. Location (City or To	Street end Numb vn, Stete)	er or Aurei Route N	um <i>ber</i> ,	
pletaly fill	2	29e. Certifier 1 XCertifying Phyone) 2 Medical Exam	rsician: To the best iner: On the basis end menner s	of examine	wledge, deeth occ tion end/or investi	curred et the gation, in my	ime, dete end place opinion, deeth occ	e, end due to the urred et the time,	ceuse(s) end me dete end place,	nner es steted. and due to the ceuse	e(s)	
To the comp	-	9b. Signature end title of certifier	٨			29c. Licer	se number		29d. Date signe	d (Month, Dey, Year,)	
	-	> hundler	<i>y</i>	d = 20 /00	00-) (**		42403		January	19, 1998		
1	3	0. Name end eddress of person who o						D G G G G G G G G G G				
		Raj Mathur M.D.	100 Irv	Tud 2	treet N.	W. Was	shington :	DC 20010				



Please

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		tificate of			. No.	8 02	500	
est) nn	Fitze			2. Date of Deeth Month January	Dey 8,	1998	3. Time of Death 11:25 AM	
va street and orial H	number) [ospital		4b. City, Town, or Lo		4c. County of Death Frederick			
Sex 7. Age (In yrs. last birthdey) If Under 1 Yaa			If Undar 24 Hrs.	8. Data of Birth	/l	9. Birthp	lece (Stete or Foreign	

Funeral Director

Physician

/Medical

1. Decedent's Neme (First, Middle, L.

Margaret Sue

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0020

Physician /Medicai Examiner

any Injury or conce.

attending physician end for use as the buriel-transit The lew requires that the deeth certificate be executed signed by the a d be detached f pega 2 s After this certificate or Attending Physician: director, funeral r death. 24 hours after deat Funeral Director: filled in by

Division of Vital Records, P.O. Box 68760,

4a. Facility Name (If not institution, gi Examiner Frederick Memo 5. Social Sacurity Numbar reian 1□M 2K F Months Deys 215-26-8407 May 30, 1923 Yrs. 74 Maryland Usuel Rasidenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Maryland Frederick Frederick X Yas 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 10001 Heather Ridge Dr. 21702 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armad Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status 1 Yas ZNNo If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify P 3 Widowed 4 Divorcad Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laundry worker Hospital 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Surnama) George Webster Fitze, Sr. Effie Sofire Tobery 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Barbara Marie Fitze/Sister 10001 Heather Ridge Dr., Apt. D, Frederick, Md. 21702 20b. Place of Disposition (Name of cametery, cremetory or other place)
Mt. Olivet Cemetery 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 Surial 2 Cremation 3 Removal from State Jan. 10, 1998 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Service Licensee 22. Neme end Address of Facility Keeney & Basford Funeral Home Approximate Intervel Between Onset end Death Immediate Ceuse (Final diseasa or condition resulting In deeth) Pulmonary Disease Dua to (or as e consequence of): Examiner Sequentially list conditions, if eny, leeding to Immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Kenal by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Mitral Value Regurgitation Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Wes case reference medical exeminer? Be 26. Plece of Deeth (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatiant 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: 1 Naturel 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 ☐ Accidant 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical 1<mark>ể Certifying Phyelcfan:</mark> To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es steted. 2 Medical Examiner: On the basis of examinetion end/or Investigation, in my opinion, deeth occurred at the time, date end placa, end due to the cause(s) end menner stated. (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture epal title of cartifier 047679 January 8, 1998 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

201 Thomas Johnson Dr. , Frederic Hd 2/702

State Registrar

Francis G. 31. Dete filed (Month, Day, Year)

JAN-9

32. Registrer's Signeture

Tabi Davidson

completely

within 2 To the I

Hospital

